



REGINA DOMINICAN

THE COLLEGE PREPARATORY CATHOLIC SCHOOL FOR WOMEN

Medication Authorization Form

To be completed by Physician or other licensed prescriber:

Student's Name _____ Class of _____

Address _____

Prescription _____ Dosage _____

Route _____ Time/Instructions _____

Prescription Starting date _____ Prescription Ending Date _____

Allergy, Asthma, and Diabetic Medications- e.g. Epi-Pen, Inhalers, Insulin

Student may carry medication? Yes [☐] No [☐]

Student may self-administer medication? Yes [☐] No [☐]

Over the Counter Medications _____

Dosage _____ Route _____ Frequency _____

OTC Ending Date _____ Or Until Graduation _____

Reason for medication and/or intended effect _____

Other medication student is receiving _____

Physician's Name (print) _____ Address/ Office Stamp

Physician's Signature _____

Date _____

Phone Number _____

To be completed by Parent/Guardian:

I authorize Regina Dominican High School to administer medication to my daughter according to School Board Policy and Medication Administration Procedures and Guidelines. (See attached sheet.)

Student's Name _____

Parent/Legal Guardian Signature _____ Date _____

Emergency Phone number: Mother/guardian _____ Father/Guardian _____