ST. JOSEPH
PARISH SCHOOL

All prescription medication must come in the original container with doctor's orders.

SCHOOL ADMINISTRATION OF PRESCRIPTIVE MEDICATIONS

Name of Child: _____ Birthdate: _____

Address: _____

_____

_____

_____

Telephone: _____

Medication Order:

Possible reactions:

Length of continuation:

_____
(M.D. signature)

_____
(Date)

I request that authorized school personnel administer the above medication at the prescribed times to my child.

Parent/Guardian Signature: _____ Date: _____