Medication Permission Request Form

Child's Name:	

I, the parent/guardian (*signed below*) of the child (*as listed above*) request that St. Raphael the Archangel Catholic Church Religious Education staff allow my child to have in his possession and to take the following medication according to the Health Care Provider's signed instructions on the lower part of this form.

Name of medicine	Dosage Time(s)
Name of medicine	Dosage Time(s)

I acknowledge that **Prescription medications** must come in a container labeled with my child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. The Pharmacy name and phone number must also be included on the label.

I acknowledge that **over the counter medication** must be labeled with my child's name and that the dosage must match the signed health care provider authorization, and medicine must be packaged in its original container.

Parent/Legal Guardian's Name	Parent/Legal Guardian Signature	Date

Home Phone:	
Work Phone:	

Health Care Provider Authorization to Possess and Take Medication in School

Child's Name:	Birthdate:
Medication:	Dosage:

Route to be given at the following time(s):

Special Instructions:

Purpose of medication:

Side effects that need to be reported:

Name of Health Care Provider	Signature of Health Care Provider with Prescriptive Authority License Number	Date

Phone Number	
License Number	