DIVINE SAVIOR
MEDICAL CONSENT FORM

Student Name:____

Student Address:____

Telephone Number:____

Teacher:______________________________________ Grade: ____________________

Physician Name:_____________________________________ Phone: _______________

Physician Address: ____

Name of the drug:____

Amount of dosage: ____

Time of day to be given: ____

How is it to be given: ____

Reason for the medication:____

Check one: Non-Prescription __________ Prescription __________

Person authorized to give medication: (Please fill in)
Secretary ______ Principal _______ Teacher __________

Parent/Guardian Signature: ____

Date: ____

Divine Savior Catholic School designates the school secretary to administer medication. In her absence the Principal/Teacher will administer medication. We do not administer any medication that does not have the drug store label or over the counter label on the container.

This form may be reproduced as needed.