OFFICE OF CATHOLIC SCHOOLS
ARCHDIOCESE OF MOBILE

SCHOOL AND PRE-SCHOOL PERSCRIPTION DRUG AND MEDICINE AUTHORIZATION

Full Name of Child _____ Date _____

Home Address _____ Phone _____

School _____ Grade _____ Teacher _____

Parent /Guardian _____
(Print Name)

Name of prescription/medicine _____

Prescribing doctor _____

Amount of dosage _____

Times to be given _____

I hereby authorize _____

To dispense medicine as directed.

_____
Signature of Parent/Guardian

Revised August 2007