

**ST. JEROME CATHOLIC SCHOOL  
2601 S.W. 9 th AVENUE  
Ft. Lauderdale, Fl. 33315**

**Phone # (954) 524-1990  
Fax # (954) 524-7439**

**AUTHORIZATION FOR MEDICATION**

Name of Student: \_\_\_\_\_

Grade: \_\_\_\_\_



**TREATMENT PLAN  
(to be completed by the Physician)**

\_\_\_\_\_   
Diagnosis

\_\_\_\_\_   
Date

\_\_\_\_\_   
Medication & Dosage Prescribed

\_\_\_\_\_   
Physician Name

\_\_\_\_\_   
Purpose of Medication

\_\_\_\_\_   
Phone Number

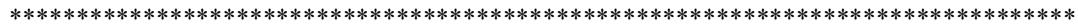
\_\_\_\_\_   
Time & Direction for Administration by School Personnel

Side Effects/special instruction (ie. Before or after meals): \_\_\_\_\_



\_\_\_\_\_   
Signature of Physician

\_\_\_\_\_   
Date



**PARENTAL PERMISSION (TO BE COMPLETED BY PARENT OR GUARDIAN)**

I grant the principal or his designee the permission to assist in the administration of each medication to be provided during the school day.

Parent Signature: \_\_\_\_\_



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