

Our Lady of Lourdes School
2124 South 32nd Avenue
Omaha, NE 68105
Phone: 341-5604
Fax: 341-9957

PHYSICIAN'S MEDICATION AUTHORIZATION
(For Prescriptions)

Student _____ Grade _____ Age _____

I request the above student receive the medication as ordered by the physician named below while in school and school related activities. I understand it is my responsibility to furnish this medication.

Parent/Guardian Signature _____

Address _____

Phone _____ Work Phone _____

NOTE: The medication is to be brought to the school office and checked in by a parent. The prescription medication is to be brought to school in the original container appropriately labeled by the pharmacy or physician. The medication and dosage should be clearly labeled. The office staff will count the medication and a parent will verify same.



PHYSICIAN DIRECTIONS

Prescription medication to be given to _____

Dosage _____ Time _____

Purpose of medication _____

Possible side effects or observations to note _____

Physician's Signature _____ Date _____

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PARENT MEDICATION AUTHORIZATION
(OVER-THE-COUNTER)

Student _____ Grade _____ Age _____

I request the above student receive over-the-counter medication when needed. I understand it is my responsibility to furnish this medication.

Parent/Guardian Signature _____

Address _____

Phone _____ Work Phone _____

NOTE: The medication is to be brought to the school office and checked in by a parent.