



# Diocese of Palm Beach



## Medication Form for 2026-2027 School Year

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_  
(please print legibly)

It is necessary that medication be given as follows:

Name of medication: \_\_\_\_\_  
(Brand Name. Also, Medication Name as it appears on container (if generic equivalent))

Prescription No.: \_\_\_\_\_

Color, if applicable: \_\_\_\_\_

Please circle form of medication:

Tablet Pill    Capsule    Inhalation    Liquid    Other/Specify: \_\_\_\_\_

Dosage: \_\_\_\_\_ How often/What time given: \_\_\_\_\_

**\*\*NO injections will be given, except in an extreme emergency, such as allergy to bee sting or the like.**

The parent knows of this request and is in full agreement that this medication will be supplied as needed. Should the student manifest any of the following symptoms caused by the medication, please contact the parent or my office.

Remarks: \_\_\_\_\_

Known allergies: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print Parent Name

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

Please print Physicians name: \_\_\_\_\_

\_\_\_\_\_  
Physicians Signature

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