

**St. Matthew School**  
**Medication Dispensing Authorization**

Student's Name \_\_\_\_\_ Grade/teacher \_\_\_\_\_

Medication \_\_\_\_\_

Dosage of medication \_\_\_\_\_

Dates and Times to be administer \_\_\_\_\_

Diagnosis/Purpose of medication: \_\_\_\_\_

**Medication will only be dispensed if the medication is in the original packaging.**

I give permission for my child to be given the above medication.

Parent signature \_\_\_\_\_

Date \_\_\_\_\_