

**St. Thomas The Apostle School  
Long Term Medication  
Physician & Parent Permission Form**

The following child, \_\_\_\_\_, has a medical condition which requires medications to be available and/ or administered during the school day for longer than two weeks.

Allergies: \_\_\_\_\_

Condition(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication: \_\_\_\_\_  
Route: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

\_\_\_\_\_  
Printed name of AZ Licensed Physician      Date      Office Phone Number

\_\_\_\_\_  
Signature of Physician      AZ License Number

The Parent/Guardian of \_\_\_\_\_, agrees to provide the above medication(s) in the original labeled bottle/container. The medication must be picked up by the parent/guardian if it is discontinued, expired, or on the last day of school. Otherwise it will be discarded. The Parent/Guardian also agrees to notify the Health Office of any changes in the Prescription or in the child's medical condition.

\_\_\_\_\_  
Parent/ Guardian Signature      Date

\_\_\_\_\_  
Daytime Telephone Number