

**ST. THOMAS AQUINAS ACADEMY SECONDARY CAMPUS  
MEDICAL AUTHORIZATION FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

Description of Medication to be administered: (type, frequency etc.)

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Length of time student is to receive this: \_\_\_\_\_

Is the school office able to give your child(ren) Tylenol? Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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