REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS
THIS FORM MUST BE RENEWED EACH SCHOOL YEAR

TO BE COMPLETED BY PARENT: (for all medications)

Name of Student ___________________________ Grade: ___________________________

Name of Medication ___________________________ Dose ___________________________

Time(s) to be given ___________________________ Number of Days ___________________________

I request that my child, named above, be assisted in taking the prescribed or over-the-counter medication at school by authorized persons and will comply with the school’s policies and procedures. I have provided the medication in its original container and labeled as above.

_________________________________________  __________________________________________
Date                                        Daytime Telephone Number     Parent/Legal Guardian Signature

TO BE COMPLETED BY A LICENSED PHYSICIAN: (for all prescriptions and aspirin)

Name of Medication ___________________________ Purpose of Medication ___________________________

Dosage Prescribed ___________________________ Time Scheduled ___________________________ Dose Form (tablet, liquid, etc) ___________________________

Date of Prescription ___________________________ Length of Time This Medication Will Be Necessary ___________________________

PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE EFFECTS, COMMENTS:

_________________________________________

The student named above, for whom this medication is prescribed, is under my care.

Print Name of Physician ___________________________ Signature of Physician ___________________________

Telephone Number ___________________________ Date ___________________________

Diocese of Oakland, School Department August 2001