

SAINT EDWARD SCHOOL  
5788 THORNTON AVE.  
NEWARK, CA 94560  
(510) 793-7242  
(510) 793-3189 (FAX)

**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 \_\_\_\_\_