# ALL SAINTS CATHOLIC SCHOOL

**22870 Second Street, Hayward, CA 94541**
**(510) 582-1910 FAX (510) 582-0866**

## REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS
## THIS FORM MUST BE RENEWED EACH SCHOOL YEAR
## ONE FORM PER MEDICATION PLEASE

### 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 PHYSICAN: (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