St. Catherine of Siena School

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Request for Medication to be taken during school hours

This form must be renewed each school year

To be completed by parent: (1 form per medication, including over the counter)

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 medication at school by authorized personnel. I agree to 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/Guardian Signature
______________	____________________	____________________________

To be completed by a licensed physician: (1 form per medication, including over the counter)

Name of medication	Purpose of medication
______________________________	______________________________

Date prescribed	Dosage	Frequency	Duration
______________	______________	______________	______________

Precautions, special instructions, possible side effects, comments:

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

Print name of Physician	Signature of Physician
______________________________	______________________________

Date	Telephone number
______________________________	______________________________

School personnel: Please record medication given on a students Medication Administration Log

09/14/18