SAINT LEO THE GREAT CATHOLIC SCHOOL

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4238 HOWE STREET | OAKLAND, CA 94611 | 510-654-7828

# 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 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 |
|---|---|
| | |