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

790 Calhoun Street, Hayward, California 94544 (510) 538-5885 www.sclementschool.org

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