Assumption School
1851-136th Avenue, San Leandro, CA 94578
Phone-510-357-8772 Fax 510-357-7018

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