

**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**

**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