Holy Family Catholic School
3005 W. Kathleen Avenue
Coeur d' Alene, ID 83815
(208) 765-4327 Fax: (208) 664-2903

MEDICATION REQUEST FORM

Please Note: ***This form must be completed and signed by the physician, dentist, or a licensed health professional prescribing within the scope of his/her prescriptive authority and the parent. This form is for both **prescription and non-prescription medication.

Parent Request

Student Name: _____ School: Holy Family Catholic School

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to dispense medication to the above identified student in accordance with the prescription or doctor's instructions for the period commencing with the _____ day of _____, 20___ through the _____ day of _____, 20__. I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed.

SIGNATURE: _____ DATE: _____

Telephone #: Home: _____ Work: _____

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PHYSICIAN/DENTIST/LICENSED HEALTH PROFESSIONAL PRESCRIBING WITHIN THE SCOPE OF HIS/HER PRESCRIPTIVE AUTHORITY REQUEST

MEDICATION (Name, Dosage): _____
ADMINISTRATION SCHEDULE: _____
REASON FOR MEDICATION: _____

******FURTHER INSTRUCTIONS (possible reactions, etc): This section must be completed if medication is to be dispensed for more than 15 days. _____

_____

To be completed and signed for PRESCRIPTION MEDICATIONS ONLY!

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above for the period commencing with the _____ day of _____, 20__ through the _____ day of _____, 20__ as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

_____ _____
Date of Signature Physician's, dentist's, or a licensed health professional prescribing within the scope of his/her prescriptive authority Signature

Name: _____