Appendix 6009A

Our Lady of Guadalupe School

40374 Fremont Boulevard
Fremont, CA 94538

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:

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The student named above, for whom this medication is prescribed, is under my care.

____ ____

Print Name of Physician Signature of Physician

____ ____

Telephone Number Date