REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(to be completed by parent/guardian or physician)

Student's name ______________________________________ Date _________________

Name of medication ____

Purpose of medication/diagnosis ____

Prescribed dosage ____________________________ Time schedule at school ________________

Length of time medication will be necessary ____

Parent's/Physician's recommendations (check where applicable):

_______ Medication will be kept in the Attendance Office.

_______ Medication will be carried by the student.

_______ Medication may have adverse effects (explain): __________________________________
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_______ Special Instructions/Comments: ____

I request that my child be allowed to take the above medication at school according to the stated instructions and in compliance with school policy. I further understand that it is solely the responsibility of my child, and not of Bishop Montgomery High School personnel, to verify that the medication being taken is the correct medication and is being taken properly.

Parent/Guardian Signature ____
Home Phone Number _________________________________
Emergency Phone Number ____________________________________