

Holy Spirit Catholic School

Medication Request Form



Each student is required to have a medication request form on file each year for medications that need to be administered during the school day. Medication must be in the original container and properly labeled with the student's name.

STUDENT NAME: _____ **GRADE:** _____

Over the Counter Medication

Medication 1:

Dosage:

As Needed? Scheduled?

Time(s) to be given:

Reason:

Medication 2:

Dosage:

As Needed? Scheduled?

Time(s) to be given:

Reason:

Prescription Medication

Medication 1:

Dosage:

As Needed? Scheduled?

Time(s) to be given:

Reason:

Medication 2:

Dosage:

As Needed? Scheduled?

Time(s) to be given:

Reason:

I authorize Holy Spirit Catholic School to assist my child in taking the above medication. I will not hold liable any member of Holy Spirit Catholic School staff or faculty who is directed by me to assist my child in taking this medication. I am also stating that I have given the above medication to my child previously, and he/she is not allergic to it and has had no negative side effects.

Signature of Parent/Guardian

Phone Number

Date