

**St. Isidore School**  
**435 La Gonda Way, Danville, CA 94526**  
**(925)837-2977 or Fax (925) 837-2407**

**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
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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
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**TO BE COMPLETED BY A LICENSED PHYSICIAN: (for all prescriptions and aspirin)**

Name of Medication	Purpose of Medication
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Dosage Prescribed	Time Scheduled	Dose Form(tablet, liquid, etc)
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Date of Prescription	Length of Time This Medication Will Be Necessary
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**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
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Telephone Number	Date
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