ST. MICHAEL'S ACADEMY

Traditional Catholic School

"Semper Fortes in Fide"

MEDICATION REQUEST FORM

Please Note: This form must be completed and signed by the physician/dentist and the parent.
This form is for all medication and for both prescription and non-prescription medication.

PARENT REQUEST

STUDENT NAME: _____

SCHOOL: St. Michael's Academy, Spokane, WA

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorized 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 of Signature Parent or Legal Guardian

Phone Number: _____

PHYSICIAN / DENTIST REQUEST

MEDICIATION (name, dosage): _____

ADMINSTRATION SCHEDULE: _____

REASON FOR MEDICATION: _____

FURTHER INSTRUCTION (possible reactions, etc..): _____

_____

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 Signature

NAME: _____

Please Type or Print

Phone Number: _____

8500 N. St. Michael's Rd. Spokane, WA 99217 Phone: (509) 467-0986 Fax: (509) 467-2425