



HOLY FAMILY
S C H O O L 4

217 West Daisy Lane
New Albany, Indiana
7150
812-944-6090
holyfamilyeagles.com

Request For Administration of Prescribed Medication

Student's Name _____

Please administer to the student named above the following medication:

Name of Medication _____

Dosage _____

Time to be given _____

Duration of Medication _____

It is understood that the medication is to be furnished to the school by the parent or guardian on a daily dosage basis. The medication is to be furnished by the pharmacy in a container labeled by the pharmacy with the following information: Prescription Number; Doctor's Name, Child's Name, Dosage, and Time to be given.

Doctor's Signature _____

Holy Family School will build an educational foundation which enables its students to make lifelong contributions to self, family, Church and community.