Holy Name School
850 Pearce Street
Fall River, Massachusetts 02720
Phone: (508) 674-9131
Fax: (508) 679-0571

STUDENT'S PRESCRIPTION DRUG FORM
(This must be completed by a physician)

Date:___________________

I hereby request the nurse or school designee to see that my child,

______________________, receives the medication as prescribed by

______________________ for the period of _________________________ to

______________________.

Medication will be supplied by me in the original bottle and labeled with my child's name, name of medication, dosage, and time to be given.

Parent/Guardian Name: (please print)____

Parent/Guardian Signature:____

The above-named child is under my care. Please give medication as prescribed by me-

Physician Name (please print)____

Physician Signature ____

Physician Address____

Physician Phone Number____

Name of medication____

Duration of treatment____

Diagnosis____