SAN FERNANDO VALLEY PROFESIONAL SCHOOL

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by parent/guardian or physician)

Student's name __________________________________ Date _______________________
(Last) (First)

Name of medication ____

Purpose of medication/diagnosis ____

Prescribed dosage _____________________ Time(s) to be taken at school ______________

Length of time this medication will be necessary _______________________________________

Parent's/Physician's recommendation (check where applicable):

____ Medication will be kept in the attendance office.

____ Medication will be carried by the student.

____ Medication may have adverse effects (explain) ___________________________________

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____ Special instructions/comments ____

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I request that my child be allowed to take the above medication at school according to the stated instructions and in compliance with school policy. I further understand that it is solely the responsibility of my child, and not San Fernando Valley Professional School Personnel, to verify that the medication being taken is the correct medication and is being taken properly.

Parent/Guardian/Physician signature ____

Parent/Guardian/Physician printed name____

Daytime phone # __________________ Emergency phone number # __________________