ST CATHERINE'S HIGH SCHOOL
Long Term Medication Request

NAME OF STUDENT _____

STUDENT'S ADDRESS_____

As parent/guardian of the above mentioned student, I request the School to dispense medicine to my child as indicated on this form. Furthermore, the school has my permission to contact the physician in regard to the medication being prescribed.

_____ _____
Date Signature (parent/guardian)

The following medication has been authorized and approved:

_____ _____ _____
Name of medication Dosage Time of Administration

_____

_____

Pharmacy _____ Phone #_____

_____ _____
Date Signature of Physician

_____
Physician's Name (printed)

_____
Date