ARROYO PACIFIC ACADEMY

41 West Santa Clara Street • Arcadia, California 91007-3100 • Tel 626.294.0661 • Fax 626.294.0677

Request For Medication Form

During School Hours For Both Prescription and Over-the-Counter

Type or print legibly in black ink. Provide all information fully and accurately.

Student's Name: _____ Date: _____

I request that my child be allowed to take the following medication at school according to the stated instructions and in compliance with school policy as stated in the *School Handbook*. I further understand that is solely the responsibility of my child, and not of Arroyo Pacific Academy personnel, to verify that the medication being taken is the correct medication and is being taken properly.

Name(s) of medication:

_____

_____

Purpose of medication/diagnosis:

_____

_____

Prescribed dosage:

_____

_____

Time schedule at school:

_____

_____

Length of time medication will be necessary:

_____

_____

Explain how the medication may have adverse effects:

_____

_____

Special instructions/comments:

_____

_____

I give permission for the school to give my child aspirin when she/he requests aspirin: ❑ YES ❑ NO

I give permission for the school to give my child Tylenol when she/he requests Tylenol: ❑ YES ❑ NO

_____ _____

Parent/Guardian Signature Date

_____ _____

Day Telephone Number Emergency Telephone Number