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 _____

HOLY NAME SCHOOL
EXTENDED CARE PERMISSION FORM
SCHOOL YEAR 2016-2017

Child's Name (Please Print)_____Grade:_____

Parent/Guardian Name and where parents can be reached between 2:30 and 5:30 p.m.:

_____

Name **Phone**

_____

Name **Phone**

In the event that there is an emergency and you cannot be reached, please give the names and numbers of those people authorized to act in your absence. (Phone number needs to be where the person can be reached between 2:30 and 5:30 p.m.).

_____

Name **Phone**

_____

Name **Phone**

If no one listed above can be reached, I want my child to be brought to the hospital Emergency Room.

_____
Parent/ Guardian Signature

Child's Physician (Please Print) _____

Physician Phone Number _____

Medical conditions, treatments and allergies we should be aware of:_____
_____

THIS PERSON(S) MAY <u>NOT</u> CALL FOR OR PICK UP MY CHILD(REN):

_____

Parent Signature:_____ Date:_____