HOLY GHOST PREPARATORY SCHOOL
2429 BRISTOL PIKE, BENSALEM, PA 19020-5298 (215) 639-2102 • FAX (215) 639-4225
WWW.HOLYGHOSTPREP.ORG

# AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

*Please note that all medications must be provided in the pharmacy labeled container or original OTC container.

This section to be completed by a parent/guardian:

School Year:_____

Student's Name:_____ Grade:_____

Health Care Provider:_____ Telephone:_____

I request that my child be assisted, by an authorized person, in taking the medication described below:

_____ _____ _____
Date Parent/Guardian Signature Telephone

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The following is to be completed by the Health Care Provider:

Name of Medication:_____

Dose:_____ Time to be given:_____

If medication is to be given "WHEN NEEDED," describe indications:

_____

How soon can it be repeated?_____

Significant side effects:_____

_____

Other Information:_____

_____ _____
Date Health Care Provider Signature