GRACE BRETHREN SCHOOLS
STUDENT HEALTH FORM H2

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS
(To be completed by a licensed physician)

_____ Male ☐ Female ☐ _____
Pupil's Last Name, First Name, Middle Initial — Date of Birth

Grace Brethren Elementary ☐ Grace Brethren Jr/Sr High ☐ ____
Grade

_____ _____
Purpose of Medication or Diagnosis — Name of Medication

_____ _____ _____
Dosage Prescribed — Time Schedule — Dose Form (Tablet/Liquid)

_____ _____
Date of Prescription — Length of Time This Medication Will Be Necessary

Special Recommendations and/or Comments: _____

_____

_____

_____ _____
Print Name of Licensed Physician — Signature of Licensed Physician

_____ _____ _____
Address — Phone No. — Date

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I request that my child, _____, be assisted in taking the above prescribed medication at school by the Health Clerk or other authorized personnel. I will comply with the school's policies and procedures. I agree to, and do hereby hold Grace Brethren Schools and its employees harmless from any and all claims, demands, cause of action, liability or loss of any sort because of, or arising out of the acts or omissions of Grace Brethren Schools or its employees with respect to this medication.

_____
Signature of Parent/Guardian — Date

_____ ____ _____
Home Address — City — State — Zip

_____ _____ _____
Home Phone — Work Phone — Pager/Cellular Phone

This form will be kept on file for the duration of the current school year.