

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: \_\_\_\_\_

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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 \_\_\_\_\_