MEDICATION ADMINISTRATION REQUEST FORM

DATE: _____

PARENT/CARER'S NAME: _____

ADDRESS:_____

TELEPHONES - Home: _____Mobile: _____

Dear Principal,

I request that my child _____ of Grade _____ be administered the following ☐ prescribed ☐ non-prescribed medication whilst at school. (please tick)

NAME OF MEDICATION: _____

DOSAGE (AMOUNT): _____ TIME: _____

☐ I have sent the medication in the original container displaying the instructions provided by the pharmacist.

☐ I have provided the medication in the original packaging (e.g. headache tablets)

☐ Where medication is ongoing I have provided the School with confirmation of the doctor's original instructions.

Signed: _____

Parent / carer's signature