MEDICATION REQUEST FORM

CHILD'S NAME: [   ]   **CLASS:** [   ]

DATE/S: [   ]   **ONGOING:** [   ]

PARENT'S NAME: [   ]

TELEPHONE:
(School Hours) [   ]

I request that my child _____ be administered the following medication whilst at school.

NAME of MEDICATION: [   ]

DOSAGE (AMOUNT): [   ]   **TIME/S:** [   ]

REASON FOR MEDICATION: [   ]

My child has already been given this medication today at [   ]

I have sent the medication in the original container displaying the instructions provided by the Pharmacist. I understand that all medication is to be kept at the school office.

Yours sincerely

_____
(Parent Signature)

SEE MEDICATION POLICY FOR MORE DETAILS