REQUEST TO ADMINISTER MEDICATION
EMERGENCY OR INTERMITTENT

Student’s Name: __________________________________________ Class: __________________________

Name of prescribed medication: ____________________________________________________________

Prescribed for (name of medical condition): ________________________________________________

Prescribed dosage: _______________________________________________________________________

Time: __________________ Start date: __________________ Concluding on: ________________________

Special storage requirements if any e.g. in refrigerator: ______________________________________

Special instructions for administering the prescribed medication/s e.g. must be taken with food or with a

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

□ YES □ NO If YES, please provide more information:

________________________________________________________________________________________

_______________________________________________________________________________________

If your child administers his or her own medication at home, do you request that he she self administers this medication at school? □ YES □ NO

(Note: The Principal needs to approve a decision for a student to self administer)

If your child self administers the medication at home, what level of support do you provide? (please describe): __________________________________________________________________________

Medication delivered to school by: _________________________________________________________

Parent Name: _________________________________ Contact Telephone No.: ___________________

Parent Signature: _____________________________ Date: ________________________

The school will make every endeavour to provide the medication at the times requested. It is your child’s responsibility to come to the office for administration of medication.