MEDICATIONS REQUEST FORM

(for medications to be administered at school)

Student's Name & Grade	
Date:	
Parents Name:	
Address:	
Telephone:	**W** **Mob.**
Name of medication:	
Dosage: (amount to be taken)	
Time: Time to be taken) am, pm, after eating	

Dear _____

I request that my child _____, in Grade _____ be administered the above named medication whilst at school, as prescribed by the child's medical practitioner.

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

_____ _____

Parent signature **Date**

(For Staff only)

Date and time	Dosage	Administered by	Signed