MEDICATION REQUEST FORM

DATE/S TO BE ADMINISTERED: (Inclusive)

PARENT's NAME:

ADDRESS:

TELEPHONE:
(Busniness Hours)

Dear Principal/Deputy Principal,

I request that my child ______________________ be supervised self-administering the
(Child's Name)
following medication whilst at school, as prescribed by the child's medical practitioner.

NAME of MEDICATION:

DOSAGE (AMOUNT):

Name of Doctor:______________________________

Telephone No.______________________

TIME:

I have sent the medication in the original (or dosette) container displaying the instructions provided by the pharmacist.

Yours sincerely

_______________________ (Parent Signature)

___________ (Date)

FOR THE CLASSROOM TEACHER

NAME OF STUDENT: ____
NAME OF TEACHER: ____
TIME TO COME TO OFFICE TO TAKE MEDICATION: _____________