STUDENT:

PRESCRIBED MEDICATION REQUEST FORM

DATE:

PARENT’S NAME:

ADDRESS:

TELEPHONE:

(Business Hours)

Dear Principal,

I request that my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be administered the following medication whist at school, as prescribed by the child’s medical practitioner.

NAME OF MEDICATION:

DOSAGE (AMOUNT):

INSTRUCTIONS FOR ADMINISTRATION OF MEDICATION:

TIME:

DATES FOR MEDICATION:

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent / Guardian Signature)

*For long-term medication please attach a doctor’s recommendation and a cover letter from parent, signed and dated. This request must be renewed every three months.*

NON PRESCRIBED MEDICATION REQUEST FORM

STUDENT:

DATE:

PARENT’S NAME:

ADDRESS:

TELEPHONE:

(Business Hours)

Dear Principal,

I request that my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be administered the following medication whist at school.

NAME OF MEDICATION:

DOSAGE (AMOUNT):

REASON FOR MEDICATION:

INSTRUCTIONS FOR ADMINISTRATION OF MEDICATION:

TIME (If applicable):

DATES FOR MEDICATION:

I have sent the medication in the original container displaying the relevant instructions and my child’s name.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_