

Request for school to administer medicine



Name of child..... Class.....

Date of birth.....

Medical condition/illness

Medicine

ANY MEDICINE MUST BE IN THE ORIGINAL CONTAINER WITH YOUR CHILD'S NAME CLEARLY VISIBLE

Name of medication (as described on the container)
.....

Expiry date.....

How long will your child need to take this.....

Dosage and method.....

Time to be taken

Does it need to be placed in a fridge? -Y/N

Special precautions/instructions/side effects? If yes, please specify.....

Self-administration? - Y/N

Procedures to take in an emergency.....

Contact Details

Name.....

Daytime telephone no.....

Relationship to child.....

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is to be stopped.

I can also confirm that the above named child has previously taken this medication without adverse effects.

Signed.....

Date.....