REQUEST FROM PARENTS/GUARDIANS FOR THE SCHOOL TO

ADMINISTER MEDICATION TO A STUDENT

STUDENT

STUDENT SURNAME

DATE OF REQUEST

STUDENT FIRST NAME

YEAR | HOUSE

DR

MEDICAL PRACTICTIONER

MEDICAL PRACTICTIONER'S PHONE NUMBER

CONDITIONS

HEALTH/MEDICAL CONDITIONS:

COULD YOUR CHILD EXPERIENCE AN EMERGENCY REACTION IN RELATION TO THIS CONDITION? (PLEASE TICK ONE)

☐ YES ☐ NO

MEDICATION

NAME OF MEDICATION

PRESCRIBED FOR: (NAME OF CONDITION)

PRESCRIBED DOSAGE

PLEASE NOTE: ALL PRESCRIPTION MEDICATIONS NEED TO BE SUPPLIED IN THEIR ORIGINAL CONTAINER WITH PHARMACY LABEL

DATES TO GIVE MEDICATION

TIMES TO GIVE MEDICATION

STORAGE (EG. REFRIGERATE)

INSTRUCTIONS (EG. TAKE WITH FOOD)

THROUGH INFORMATION YOU HAVE OBTAINED FROM YOUR DOCTOR OR ACQUIRED YOURSELF, ARE YOU AWARE OF ANY LIKELY SIDE EFFECTS FROM THE PRESCRIBED MEDICATION? (PLEASE TICK ONE)

☐ YES ☐ NO

SIDE EFFECTS:

IF YOUR CHILD ADMINISTERS HIS OWN MEDICATION AT HOME, DO YOU REQUEST THAT HE ADMINISTERS THIS MEDICATION AT SCHOOL? (PLEASE TICK ONE)

☐ YES ☐ NO

SUPPORT REQUIREMENTS:

NAME OF PERSON WHO WILL CARRY THE MEDICATION TO SCHOOL

ANY OTHER REQUESTS FOR MEDICATION ADMINISTRATION SUPPORT

AUTHORITY

PARENT OR GUARDIAN NAME

EMERGENCY PHONE NUMBER

PARENT OR GUARDIAN SIGNATURE

DATE

ADMINISTRATION RECORD

SCHOOL USE ONLY

DATE	TIME	SIGNATURE

DATE	TIME	SIGNATURE

DATE	TIME	SIGNATURE