REQUEST TO

ADMINISTER MEDICATION TO A STUDENT

PARENTS PLEASE COMPLETE A SEPARATE FORM FOR EACH MEDICATION
PROVIDE FORM AND MEDICATION (REQUIRED AMOUNT ONLY) IN CLIPSEAL BAG TO TEACHER IN CHARGE

STUDENT

SURNAME

GIVEN NAME(S)

YEAR | HOUSE

DR

NAME

PHONE NUMBER

CONDITIONS

MEDICAL CONDITION(S) REQUIRING MEDICATION:

MEDICATION

NAME OF MEDICATION

PRESCRIBED DOSAGE

QUANTITY PROVIDED (E.G. 10 TABLETS)

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

DATES TO GIVE MEDICATION

TIMES TO GIVE MEDICATION

STORAGE (EG. REFRIGERATE)

INSTRUCTIONS (EG. TAKE WITH FOOD)

ARE YOU AWARE OF ANY LIKELY SIDE EFFECTS FROM THE PRESCRIBED MEDICATION? (EG. NAUSEA)

☐ YES ☐ NO

SIDE EFFECTS:

AUTHORITY

PARENT NAME

PHONE NUMBER

PARENT SIGNATURE

DATE

TEACHER IN CHARGE PLEASE COMPLETE THE TABLE BELOW WHEN MEDICATIONS ARE ADMINISTERED
COMPLETED FORM TO BE RETURNED TO SCHOOL HEALTH CENTRE ON RETURN TO CAMPUS

DATE	TIME	SIGNATURE

DATE	TIME	SIGNATURE

REQUEST FROM PARENTS TO

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CONTINUED

DATE	TIME	SIGNATURE

DATE	TIME	SIGNATURE