REQUEST FROM PARENTS TO

ADMINISTER MEDICATION TO A STUDENT

PLEASE COMPLETE A SEPARATE FORM FOR EACH MEDICATION

STUDENT

STUDENT SURNAME		DATE OF REQUEST	
STUDENT GIVEN NAME(S)		YEAR | HOUSE	

DR

MEDICAL PRACTICTIONER'S NAME		MEDICAL PRACTICTIONER'S PHONE NUMBER	

CONDITIONS

MEDICAL CONDITION(S) REQUIRING MEDICATION:

MEDICATION

NAME OF MEDICATION			
PRESCRIBED DOSAGE			

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? (PLEASE TICK ONE) ☐ YES ☐ NO

SIDE EFFECTS:

AUTHORITY

PARENT NAME		EMERGENCY PHONE NUMBER	
PARENT SIGNATURE		DATE	

SCHOOL USE ONLY
ADMINISTRATION RECORD

DATE	TIME	SIGNATURE

DATE	TIME	SIGNATURE

PLEASE RETURN COMPLETED FORM TO THE HEALTH CENTRE