REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

I/We wish to inform you that it is necessary for my/our child, _____ to be administered medication at school.

I/We therefore request, through the person(s) responsible appointed by the Principal, to have the medication listed below administered to my/our child.

I/We agree to provide a supply of the medication in the Pharmacy's container, providing the following details clearly marked on the container:

1. Name of Child _____ Class: _____
2. Medical Condition _____
3. Name of Medication _____
4. Quantity of medication to be administered _____
5. Time medication is to be administered _____

Are special arrangements necessary to administer the drug or monitor the student after drug administration? YES NO If yes give details

_____
_____

Duration for Medication (eg. specific dates/term/) _____

I/we understand it is the responsibility of parents/caregivers to ensure all medication is in date and sufficient quantity of medication is supplied for the duration of time required.

The school will not be responsible for the follow up of out-of-date medication or where insufficient amount is supplied.

The Principal has the discretion to refuse medication to be administered.

Name of Parent/Guardian_____ Phone Number: _____

Signature of Parent/Guardian: _____ Date : __/__/____

Prescribing Doctor (Print Name): _____ Phone Number_____