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:

I/We agree to provide any medical reports to and to notify the school of any changes in medication, condition, or dosage.

STUDENT NAME		
YEAR AND CLASS		
DATE OF BIRTH		
NAME OF MEDICATION		
DOSAGE AND FREQUENCY TIME OF MEDICATION		
PRESCRIBING HEALTHCARE PRACTITIONER		
REASON FOR MEDICATION		
START DATE:	END DATE:	
ADMINISTRATION INSTRUCTIONS		
POSSIBLE SIDE EFFECTS		
ALLERGIES OR OTHER MEDICATIONS		
PARENT NAME:	PARENT SIGNATURE	DATE: -----/----/2024
EMERGENCY CONTACT NUMBER		

THIS PERMISSION FORM IS VALID FOR THE DURATION OF TREATMENT UNLESS THIS IS PERMANENT MEDICATION, IN THAT CASE, THE PERMISSION FORM IS VALID FOR ONE SCHOOL YEAR ONLY.