Request by Parent for school to administer medication

The school will not give your child medicine unless you complete and sign this form, and the Principal has agreed that only the Nurse can administer the medication.

DETAILS OF PUPIL

Name _____

Date of Birth _____ _____Gender _____

Class _____ Teacher _____

Condition or illness: _____

_____

_____

MEDICATION

Name/Type of medication (as described on the container)

_____

_____

For how long will your child take this medication:

_____

_____

_____

Date dispensed: _____

Full directions for use:

_____

_____

Dosage and method:

_____

_____

Timing: _____

Special precautions:

_____

_____

Side effects:

_____

_____

Self administration: _____

Procedures to take in an Emergency:

_____

_____

CONTACT DETAILS

Name: _____

Daytime Telephone No. _____

Relationship to Pupil _____

Address: _____

I understand that I must deliver the medicine personally to the NURSE and accept that this is a service which the school is not obliged to undertake.

Date: _____ Signature(s): _____

Relationship to pupil: _____