



REQUEST FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICATION

Full name of pupil:			
Class:		DOB:	
Address:			
Illness/Condition:			
Name of Medication:		Date dispensed:	
Dosage and method:		Times of administration:	
End date for administration:		Expiry date of medication:	
Side effects:			
Any other instructions/special precautions:			

The above information is, to the best of my knowledge, accurate at the time of writing and I give my consent to St. Luke's staff administering medication in accordance with the school policy.

I understand that medication must be delivered to school either by myself or my child's passenger escort. I understand medication will be sent home at the end of each school term and if it is to continue, that I will complete a new form and return in date medication at the start of the following term.

I will inform the school immediately if there is any change in dosage or frequency of the medication or if the medication is stopped.

NB: ALL MEDICATION MUST BE PRESCRIBED AND IN ITS ORIGINAL PACKAGING

Parent/Guardian Signature:		Contact Number:	
		Date:	

