REQUEST FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICATION

Please complete this form each time the medication is handed in (even if repeated), sign and return it to the school so medicine can be administered to your child by a trained First Aider.

Full Name of Pupil …… Class ……..

Address …… Date of Birth ……/……/……

Illness/Condition ……..

Name of Drug …….. Strength of Drug ……

Date dispensed ……/……/…… Dosage and method ……..

End date to stop administration of medication ……

What time to administer ……..

Side effects / Special Instructions……

Medication received into school:

Number of tablets / ml received	Signature of responsible person handing over drugs	Signature of designated person receiving drugs into school	Signature of class member
	Print Name	Print Name	Print Name

I understand that any 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 give my consent to school staff administering medication in accordance with the school policy. I will inform the school immediately if there is any change in dosage or frequency of the medication or if the medication is stopped.

Name …….. Relationship to pupil ……..

Daytime Phone Number …… Date……..

ALL MEDICATION MUST BE PRESCRIBED AND IN ITS ORIGINAL PACKAGING