REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Pupil's Name	
Class	
Address	
Condition/Illness	
Name/Type of Medication	
No of days to administer medication	
Date treatment started	
Frequency of dosage	
Timing	
Additional Instructions (before/after food)	
Storage Instructions	
Possible side effects	
Advised to seek medical attention	

EMERGENCY CONTACTS

Name	
Relationship to pupil	
Telephone Nos	

I understand that I must deliver the medicine personally to the school office. I accept that the school has a right to refuse to administer medication.

Name: .....

Relationship to child: .....

Signed: .....

Date: .....