



REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

I/We wish to inform you that it is necessary for my/our child, _____ to have 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**:

1. Name of Child
2. Name of Medication
3. Quantity of medication to be administered.

Name of Parent/Guardian: Phone Number:

Signature of Parent/Guardian: Date :

PLEASE PRINT IN BLOCK LETTERS THE FOLLOWING DETAILS:

Student Name:..... Class:

Condition: Name of Medication:

Are special arrangements necessary to administer the drug or monitor the student after drug administration? YES NO

If yes give details

.....
.....

Quantity/Method of Administering Medication:

Duration of need for Medication (eg. specific dates/term/)

.....

Prescribing Doctor (Print Name): Phone Number:

Signature of Prescribing Doctor signature: Date:

OFFICE USE ONLY

TIME	DATE	DOSAGE	ADMINISTERED BY	INITIALS	CHECKED	INITIALS

THIS PERMISSION FORM IS VALID FOR THE DURATION OF TREATMENT UNLESS THERE IS PERMANENT MEDICATION (eg: ALLERGIES) IN THAT CASE, PERMISSION FORM IS VALID FOR ONE SCHOOL YEAR ONLY.



Inspiring hearts and minds