Request for administering prescribed medication at school (not for an ongoing medical condition)

Please complete this form on the basis of information provided by your medical practitioner and/or pharmacist and return it to the school.

Please ensure that the container for the medication has the <u>pharmacist's label on it</u>, with your child's details.

Name of child: ______________________________

Roll Class: __________

Scholastic Year: __________

Name of prescribed medication: ______________________________

Prescribed for (**name of medical condition**):

____

Prescribed dosage:

____

What are you requesting the school to do?

____

____

<u>Medication</u>
Special storage requirements if any e.g. in refrigerator:

____

Special instructions for administering the prescribed medication/s e.g. must be taken with food or with a glass of water:

____

Through information you have from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

Yes ☐ No ☐ If Yes, Please provide more information:

____

Name of person who will carry the medication to school: ______________________________

Medical Practitioner Name:______________________________Phone: ______________

Address: ______________________________

Parent Name: ______________________________

Parent or carer signature:______________________________Date: __________