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| **REQUEST TO ADMINISTER MEDICATION TO MY CHILD WHILE IN THE CARE OF THE SCHOOL** (Note: Medication must be provided by parents/carers) |
| **STUDENT’S NAME** |  |
| **DOB** |  |
| **FORM/CLASS** |  |
| **NAME OF MEDICATION** |  |
| **DOSE/FREQUENCY (MAYBE AS PER PHARMACIST’S LABEL)** |  |
| **ROUTE OF ADMINISTRATION (E.G. BY MOUTH)** |  |
| **EXPIRY DATE OF MEDICATION** |  |
| **DATES of ADMINISTRATION** | **FROM: / / 202 TO: / /202** |
| **STORAGE REQUIREMENTS: (E.G. REFRIGERATOR)** |  |
| **PARENT/CARER SIGNATURE** |  |
| **PARENT/CARER NAME** |  |
| **DATE** |  |