MEDICATION REQUEST FORM

DATE:

PARENT's NAME:

ADDRESS:

TELEPHONE:
(Business Hours)

Dear Principal,

I request that my child _____ be administered the following medication
(Child's Name)
whilst at school, as prescribed by the child's medical practitioner.

NAME of MEDICATION:

DOSAGE (AMOUNT):

TIME:

I have sent the medication in the original container displaying the instructions provided by the pharmacist.

Yours sincerely

_____
(Parent Signature)

References: SOTF Reference Guide 4.5.2 Students and Medication