

MEDICATION REQUEST

Date: _____

Child's Name: _____ Class _____

Address: _____

Parent's Name: _____

Day Time Telephone Number _____

Parent's Signature: _____

SHORT TERM MEDICATION ORDER

Name of Medication: _____

Reason for Medication: _____

Dose: _____

Time to be given: _____

Please tick a box and fill in date/s:

Today only _____

Until full course is taken: _____

Dates: From _____ To _____

LONG STANDING MEDICATION REQUEST

I request that my child be administered the following medication whilst at school if he/she presents to sick bay with _____

Reason for medication

Name of Medication: _____

Dose: _____

I have sent this medication to the school in the original container displaying the instructions and recommended dosage.

(Please note: Prescription medication can only be given to your child if it has **their** name printed on it as prescribed by your doctor. We cannot administer prescription medication with a sibling or parents name on it.

Over the counter medication must be age appropriate. Eg: We cannot administer medication designed for adults to children under the age of 12 unless accompanied by a Doctors letter of support.)