REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION

(Note: If your child is to take more than one prescribed medication, please attach a separate “Request for Administering Prescribed Medication” form)

Name of student: ________________________________________________________ Class: __________

Name of prescribed medication: ___________________________________________________________

Medical Condition: ________________________________________________________________________

Prescribed dosage: _______________________________________________________________________

(Note: If the prescribed dosage changes, you will need to complete a new “Request for Administering Prescribed Medication” form)

What are you requesting the school to do? __________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Special storage requirements (eg. refrigeration): _______________________________________________

Special instructions for administering the prescribed medication (eg must be taken with food/water): _________________________________________________________________

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication? ☐ No ☐ Yes

If yes, Please provide more information: ____________________________________________________
________________________________________________________________________________________

If your child administers his or her own medication at home, do you request that he or she self administers this medication at school? ☐ No ☐ Yes

If your child self administers the medication at home, what level of support do you provide? (Please describe): __________________________________________________________________________
________________________________________________________________________________________

PARENT/CARER

NAME: _____________________________ SIGNATURE: _______________________
DATE: ______________________________

SCHOOL PRINCIPAL

MRS ROS ROWORTH
SIGNATURE: _______________________
DATE: _____________________________

Saved As: Request for Administering Prescribed Medication/Office/2013/Medication