



## REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

### DETAILS OF PUPIL

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Class/Form: \_\_\_\_\_

Condition of illness: \_\_\_\_\_

### MEDICATION

Name/type of medication (as described on the container)

\_\_\_\_\_ Expiry date: \_\_\_\_\_

For how long will your child take this medication:

\_\_\_\_\_

### Full directions for use:

Dosage: \_\_\_\_\_

Timing: \_\_\_\_\_

Any possible side effects:

\_\_\_\_\_

Parental Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to pupil: \_\_\_\_\_