Parental Request to Administer Prescription Medication

Name of child:	Child's date of birth:
Child's class name:	Name of parent completing this request:
Name of health care professional who prescribed medication:	Emergency contact name and telephone number:

Name of Medicine (Medicine must be provided in original containers with pharmacy labels)	
Dose required (please ensure measuring spoon or equivalent is provided if needed)	
Time medication is required*	
Date and duration of treatment (Please collect any unused medicine at the end of the treatment period)	
Storage requirements for medicine	
Other information	

*Three doses a day can be given outside the school day (breakfast, afterschool, bedtime). Please only ask us to administer medication in school when essential.

Please administer the medication detailed above to my child.

I have read and understood the school's Policy for Supporting Students with Medical Conditions and for the Administration of Medicine.

Signed: **Date:**

Print name:

To be completed by a member of school staff

Medicine and form received by:	Date received:
Storage arrangements:	Do you agree to it is in the child's best interest to receive this medication (see paragraph 10 of policy)