Parental Request to Administer Non-Prescription Medication

NEW FORM REQUIRED FOR EACH DAY OF TREATMENT

Name of child:	Child's date of birth:
Child's class name:	Name of parent completing this request:
Emergency contact name and telephone number:	Reason that medication is needed:

Name of Medicine Medicine must be provided in original containers	
Date required Please contact the school office at the end of the day to receive unused medicine and be given details of medication that has been administered to your child.	
Dose required Please ensure measuring spoon or equivalent is provided if needed	
Time medication is required Analgesic medication will only be administered if needed at the time	
Time and size of last dose	
Size and number of doses in last 7 days	
Other information	

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)