

**Request for children requiring administration of prescribed medication at school**

*(Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication.)*

Please complete this form on the basis of information provided by your medical practitioner and/or pharmacist and return it to the school. The school will then contact you again to confirm arrangements.

Please advise the school principal at any time if there are changes in the information about your child's health care needs.

Name of child:  
Roll Class:  
Scholastic Year:

Name of prescribed medication: \_\_\_\_\_

Prescribed for (name of medical condition):  
\_\_\_\_\_

Prescribed dosage:  
\_\_\_\_\_

What are you requesting the school to do?  
\_\_\_\_\_  
\_\_\_\_\_

Medication  
Special storage requirements if any e.g. in refrigerator:  
\_\_\_\_\_

Special instructions for administering the prescribed medication/s e.g. must be taken with food or with a glass of water:  
\_\_\_\_\_  
\_\_\_\_\_

Through information you have from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

Yes                       No                       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? (Note: The Principal needs to approve a decision for a student to

self-administer).

Yes

No

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

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Name of person who will carry the medication to school: \_\_\_\_\_

Medical Practitioner Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Parent or carer signature: \_\_\_\_\_ Date: \_\_\_\_\_

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