Our Lady Immaculate Catholic Primary School

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Pupil's Full Name: _____ Class / Form: _____

Address: _____

Condition / Illness: _____

Name / Type of Medication: _____

For how long will child be required to take medication? _____

Date Treatment Started:

_____

Frequency of Dosage: _____ Timing: _____

Additional instructions / information: (e.g.: before / after food, interaction with other medicines, possible side effects, storage instructions) _____

_____

_____

__

Emergency Contacts:

Name: _____ Relationship to child: _____

Daytime telephone no: _____

OR

Name: _____ Relationship to child: _____

Daytime telephone no: _____

I understand that medicines must always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration. It is the parent's responsibility to collect the medicine at the end of the school day.

I accept that the School has a right to refuse to administer medication.

Name: _____ Relationship to child: _____

Signed: _____ Date:

_____