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LIVE – LEARN – CARE

Principal: Craig Partridge Assistant Principals: Lisa Stewart - James Eagleton - Deb Bowman (Rel)

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: 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):

____

____

Name of person who will carry the medication to school: __________________________

Medical Practitioner Name: ________________________ Phone: ______________

Address: ____

Parent or carer signature: ______________________________ Date: _________

Parent Name: ______________________________