Short Term Request for Administering Prescribed Medication

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

Student Name: ……………………………………………………… Class: ……………………

Name of prescribed medication:...

Prescribed for (name of medical condition): ....

Prescribed dosage: ………………………….. Strength: ....

Time: 12:30pm (medicine bell) ☐ ……………………………………………………………...

What are you requesting the school to do? ....

....

....

Dates to be administered: ....

Expiry date of the medication: ....

Note: if you can't provide this information now we will need to know the expiry date when the medication is given to the school.

Special storage requirements if any eg. in refrigerator: ....

....

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

....

Through information you have obtained from your doctor or got 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?

Yes ☐ No ☐

Note: the Principal needs to approve a decision for a student to self-administer.

If yes, please describe what support your child needs to administer the medication in a non-emergency situation at school. You may like to include information about how you support your child at home to administer their medication.

……………………………………. …………………………..

Parent/Carer Signature Date