

**REQUEST TO ADMINISTER MEDICATION TO MY CHILD WHILE IN THE CARE OF THE SCHOOL**

(Note: Medication must be provided by parents/carers)

<b>STUDENT'S NAME:</b>	
<b>DOB:</b>	
<b>FORM/CLASS</b>	
<b>NAME OF MEDICATION</b>	
<b>DOSE/FREQUENCY (MAYBE AS PER PHARMACIST'S LABEL)</b>	
<b>ROUTE OF ADMINISTRATION (E.G. BY MOUTH)</b>	
<b>EXPIRY DATE OF MEDICATION:</b>	
<b>DATES of ADMINISTRATION:</b>	<b>FROM: / / 201_ TO: / / 201_</b>
<b>STORAGE REQUIREMENTS: (E.G. REFRIGERATOR)</b>	
<b>NAME OF ADMINISTRATOR:</b>	
<b>PARENT/CARER SIGNATURE:</b>	<b>DATE:</b>