

MEDICATION REQUEST FORM

DATE:

PARENT'S NAME:

ADDRESS:

TELEPHONE:
(School Hours)

I request that my child _____
(Child's Name)

be supervised whilst taking medication at school, as prescribed by the child's medical practitioner.

NAME of MEDICATION:

DOSAGE (AMOUNT):

FURTHER INSTRUCTIONS:

TIME/S:

DATE FROM

TO:

I have sent the medication in the original container displaying the instructions provided by the pharmacist.

Yours sincerely,

(Parent Signature)