

Bell Primary School

Medication Request Form

I request that my child _____ in Year _____ be administered the following medication whilst at school, as prescribed by my child's medical practitioner.

DATE/S REQUIRED: _____ 20__

TIME/S REQUIRED: _____
**Please be aware that break times are 11:40am-12:20pm and 2:10pm-2:40pm. If possible, please nominate a medication time that does not fall during these times.*

NAME OF MEDICATION: _____

MEDICATION TYPE: _____
(tablet, liquid, cream, drops, etc)

For all liquid medication, an appropriate measuring tool must be provided with the required dosage clearly marked (please confirm below).

DOSAGE REQUIRED: _____

METHOD OF ADMINISTRATION: _____
(orally, topically, nasally, etc)

STORAGE INSTRUCTIONS: _____

- ☐ I have provided the medication in the **original container** displaying my child's name (if prescription-only medication) and the instructions provided by the pharmacist.
- ☐ I have provided the appropriate measuring tool or syringe, and marked the required dose to be administered (if applicable)

Yours sincerely,

(Parent signature)

(Parent name)

(Contact number)

_____/_____/_____
(Date)

IF CEASING MEDICATION AT SCHOOL

I confirm that my child, _____ in Year _____ no longer requires medication to be administered at school as of ____/____/____.

Signed,

(Parent signature)

(Parent name)

_____/_____/_____
(Date)