

Bell Primary School

Medication Request Form

Dear Principal,

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: _____

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.

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)