

WYBURNS PRIMARY SCHOOL

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Pupil's full name: _____ Class: _____

Address: _____

Condition / Illness: _____

Name/Type of Medication: _____

For how long will child be required to take medication? _____

Date treatment started: _____

Dosage: _____ Frequency of Dosage: _____

Additional instructions / information: (e.g. before / after food, interaction with other medicines, possible side effects, storage instructions) _____

I understand that I must deliver the medicine personally to the office and collect any remaining medication when the course is completed. I accept that the School has a right to refuse to administer medication.

Name: _____ Relationship to child: _____

Signed: _____ Date: _____

Emergency contacts:

Name: _____ Relationship to child: _____

Daytime telephone no: _____

OR

Name: _____ Relationship to child: _____

Daytime telephone no: _____

For school use:

Remaining medication returned to parent on _____

Or disposed of via _____ on ____/____/____