"We believe, we achieve, we succeed in God's family"

THANKFULNESS ● COMMUNITY ● COMPASSION ● TRUTHFULNESS ● COURAGE ● FORGIVENESS

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Date: _____

Pupil Name: _____

Class: _____

Condition / Illness: _____

Name of Medicine: _____

For how long will your child take this medication? _____

Dosage and method: _____

Timing of dose (before/after food) _____

Storage Instructions: _____

Possible side effects: _____

Expiry Date: _____

EMERGENCY CONTACT DETAILS:

Name: _____ Relationship to Pupil _____

Telephone Number: _____

I understand that I must deliver the medicine personally to the school office and collect any remaining medication. I accept that the school has a right to refuse to administer medication. I accept that I am accountable for checking that long term medication is exchanged before its expiry date.

Date: _____ Signed: _____

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Healthy Schools