Request to for the Administration of Medicines in School

Child's name: _____ Class: _____

Condition / Illness: _____

Name / type of medication: _____

For how long will your child take this medication: _____

Date and time of last dose: _____

When to be taken: _____

How much: _____

Possible side effects allergies: _____

_____

Comments / special instructions: _____

_____

Parent / guardian name:

I request treatment to be given in accordance with the information provided above. I understand school staff are not obliged to give medication but may do so on completion of this form. No legal liability can be accepted by the school or its staff in the event of any failure to administer the treatment or should my child suffer any adverse reaction through the administration of the treatment or medication requested.

Parent's Signature: _____ Date: _____