Request for administering prescribed medication to a student

Child’s NAME:............................................................... Class:............

(Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication.)

Name of prescribed medication: .................................................................

Prescribed for (name of medical condition): ......................................................

Prescribed dosage: ..........................................................................................

What are you requesting the school to do? ......................................................

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Special storage requirements if any eg in refrigerator: ........................................

Special instructions for administering the prescribed medication/s eg must be taken with food or with a glass of water: .................................................................

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

Yes □ No □ If Yes, Please provide more information:

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If your child administers his or her own medication at home, do you request that he or she self administers this medication at school?

Yes □ No □

(Note: The Principal needs to approve a decision for a student to self administer).

If your child self administers the medication at home, what level of support do you provide? (Please describe): ........................................................................................................

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Name of person who will carry the medication to school:.................................

Parent/Caregiver signature: .................................................................

Name:.................................................................Date:................................