PARENTAL REQUEST FOR ASSISTANCE IN ADMINISTERING MEDICATION

Name of Pupil: _____

Caregiver's Name: _____

Address: _____

_____

Contact Phone Numbers: **Home**: _____

Work: _____

Mobile: _____

Medical Condition:

_____

_____

_____

_____

Prescribed Medication: _____

_____

Dose: _____

_____

Period of time: □ Indefinite and/or as required until further notice

□ From: _____ to _____

- I certify that the information given above is correct.
- I authorise the School to administer the medication to the abovenamed pupil.
- I understand that the medication will be administered by the office staff or their nominee.

_____ _____

Parent/Caregiver's Signature Date