REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME: _____

DOB: _____

NAME OF MEDICATION: _____

DOSE:_____

_____

FOR HOW LONG WILL YOUR CHILD TAKE THIS MEDICATION? _____

_____

CONDITION: _____

I understand that I must deliver the medicine personally to the school office and accept that this is a service which the school is not obliged to undertake.

SIGNATURE OF PARENT: _____ **DATE:** _____

For school use:

DATE	TIME	SIGNATURE	NAME

pto

For school use:

DATE	TIME	SIGNATURE	NAME