CATHEDRAL CATHOLIC PRIMARY SCHOOL

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NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

(The completed form is to be kept on file by the Principal.)

To be completed by parent or guardian

I_____ (Parent/Guardian) request the Principal to provide for the
(Please Print)

administration of medicine to _____ during school hours according to
Full Name of Student)

instructions from _____. I accept full responsibility in delegating
(full name of prescribing doctor)

administration of the medication to the school.

The medication has been prescribed for the following reason:

_____

_____

Medication Details

Condition Name	Name of Medication	Dosage	Time/s of Administration	Special Instructions	Self-Administration Yes / No

Medications should be labelled with the child's name, dosage and times of administration when handed to the school. They should ideally be stored in the container that the medication was originally dispensed in.

Additional Comments

_____

_____

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medicine.

Signed: _____ Date:_____

parent/guardian