ADMINISTRATION OF MEDICINE – PARENTAL REQUEST

In order for a child to receive prescribed medicines (e.g. antibiotics), the form below must be completed and signed by the child's parent.

Staff cannot administer prescribed medicines without written permission. All medicines **must** be clearly marked with the child's full name and the prescribed dosage.

A new form must be completed if a course of medicine endures beyond a calendar fortnight.

TO BE COMPLETED BY THE PARENT/GUARDIAN (BLOCK CAPITALS)

Full name of child			
Name of parent/guardian			
Full name of prescribed medicine/lotion			
First dose due in school	Date	Time	Amount
Second dose due (if applicable)		Time	Amount
Date for last dose(s)			
Instructions for storage of medicine			
Any further instructions			

I request the school to give the doses of medicine as shown above

Signed:_____

Name: _____ Date: _____

PLEASE HAND THIS FORM, TOGETHER WITH THE CHILD'S MEDICINE, TO THE SCHOOL OFFICE.

ADMINISTRATION OF MEDICINE(S) RECORD **For office use only**

NAME OF CHILD: _____

FIRST WEEK

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
Date										
Time										
1st dose (staff initials)										
Witnessed (staff initials)										
Time										
2nd dose (staff initials)										
Witnessed (staff initials)										

SECOND WEEK

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
Date										
Time										
1st dose (staff initials)										
Witnessed (staff initials)										
Time										
2nd dose (staff initials)										
Witnessed (staff initials)										