# REQUEST TO ADMINISTER MEDICATION AT SCHOOL

**SCHOOL NAME: .....**

**STUDENT NAME: .....GENDER: .....**

**DATE OF BIRTH / / YEAR LEVEL: .....**

## To be completed by Parent / Guardian with the Medical Practitioner and returned to the SCHOOL

Please list all the medications that the student requires during school hours and any emergency medications.

| Name of Medication | Strength (e.g. 5 mg) | Dosage (e.g. 1 tablet) | Route of Administration (e.g. Oral, via nose) | Time to be given at school | Other important instructions (e.g. storage instructions or student self-administers medication) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

I request that school staff administer the necessary medication to this student while at school.
I confirm the above information provides the school with the complete and necessary

information to administer the medication. I also understand and agree that it is my responsibility (parent / guardian) to inform the Principal of any changes involving the administration of the medication and will do so in writing as specified in the schools Medication Policy.

Parent / Guardian – PRINT NAME: ……..

Signature: ……Phone: . ……..Date: ……

Authorising Medical Practitioner – PRINT NAME……..

Apply practice stamp:

Signature: ……Phone: ……..Date: ……..

This authorisation applies for the period Term * to Term *
Year:……

**NOTE:** For **school staff** to administer any medication including '*over the counter medication'*, **authorisation is required from a medical practitioner.**

*Office Only: When this course of medication concludes, please retain this form in the student's school file.*