MEDICATION REQUEST FORM

Clarinda Primary School

DATE: from [   ] **to** [   ]

STUDENT NAME: [   ]

PARENT NAME: [   ]

TELEPHONE: (Business Hours) [   ] **TELEPHONE:** (Mobile) [   ]

Dear Principal,

I request that my child _____ be administered the following medication
(Child's Name)

whilst at school, as prescribed by the child's medical practitioner.

NAME of MEDICATION: [   ]

DOSAGE (AMOUNT): [   ]

TIME/S of MEDICATION: [   ]

DELIVERY METHOD:
(tablets crushed, liquid via syringe, etc) [   ]

Medication to be stored: in office cupboard ☐ in refrigerator ☐

I have sent the medication in the original container displaying the instructions provided by the pharmacist.

Yours sincerely

_____
(Parent Signature)

Administration of medication:

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

References: Vic Govt Schools Reference Guide -
http://www.education.vic.gov.au/management/governance/referenceguide/enviro/4_5.htm

MEDICATION REQUEST FORM

Clarinda Primary School

Student's name		Grade	

Administration of medication:

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

Date: _____ Time: _____ Dosage: _____ Given by: _____ Verified by _____

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References: Vic Govt Schools Reference Guide -
http://www.education.vic.gov.au/management/governance/referenceguide/enviro/4_5.htm