## REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

I/We wish to inform you that it is necessary for my/our child, ___________________________to have medication at school. I/We therefore request, through the person(s) responsible appointed by the Principal, to have the medication listed below administered to my/our child.

I/We agree to provide a supply of the medication in the Pharmacy's container, providing the following details **clearly marked on the container**:

1. Name of Child 2. Name of Medication 3.Quantity of medication to be administered.

Name of Parent/Guardian: …………………………………………… Phone Number: ………………

Signature of Parent/Guardian: ………………………………………… Date : ……………………

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**PLEASE PRINT IN BLOCK LETTERS THE FOLLOWING DETAILS:**

Student Name:……………………………………………………………… Class: …………………………

Condition: ………………………………………… Name of Medication: ……………………………………
Are special arrangements necessary to administer the drug or monitor the student after drug administration? YES NO
If yes give details ……………………………………………………………………………………………
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……………………………………………………………………………………………………………………

Quantity/Method of Administering Medication: …………………………………………………………………

Duration of need for Medication (eg. specific dates/term/) ……………………………………………………
………………………..……………………………………………

Prescribing Doctor (Print Name): ………………………………… Phone Number: ……………………………

Signature of Prescribing Doctor signature: …………………………………… Date: ……………………………

### OFFICE USE ONLY

| TIME | DATE | DOSAGE | ADMINISTERED BY | INITIALS | CHECKED | INITIALS |
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**THIS PERMISSION FORM IS VALID FOR THE DURATION OF TREATMENT UNLESS THERE IS PERMANENT MEDICATION (eg: ALLERGIES) IN THAT CASE, PERMISSION FORM IS VALID FOR ONE SCHOOL YEAR ONLY.**