# MEDICATION REQUEST FORM

**STUDENT'S NAME:**

**DATE:**

**PARENT'S NAME:**

**ADDRESS:**

**TELEPHONE:**
**(Business Hours)**

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:**

**DATE TO COMMENCE:** **DATE TO FINISH:**

I have sent the medication in the original container displaying the doctor's instructions.

Yours sincerely

_____ _____
(Parent Signature) (Date)

Approved by the _____ _____
(Principal's Signature) (Date)