Parent Request-Administering medication in school

Student Name: _____

Date of Birth: _____

GP Practice: _____

Medication:	Reason for medication:	Dose and Time:	Time of medication at home: (If applicable)

Please tick as appropriate:

☐ Prescription Medication:

I hereby request that the school administers this medication as prescribed by our own GP. I understand that the medication must be provided in the original packaging, with the prescription sticker attached.

☐ Over The Counter Medications:

I hereby request that the school administers the medication that I have provided. I understand that it must be provided in its original packaging.

Signed: _____ (Parent/Guardian)

Print Name: _____

Date: _____