



*Note: If your child is to take more than one prescribed medication, please attach a separate request for each medication.*

SCHOOL NAME and ADDRESS: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_ Gender: \_\_\_\_\_

DATE OF BIRTH/YEAR LEVEL: \_\_\_\_\_

.....

*Please identify the medication (prescribed or 'over the counter') that the student requires during school hours including any emergency medication.*

Name of prescribed medication: \_\_\_\_\_

Dosage (e.g. 5 mg) and Route of administration (e.g. oral, by injection):

\_\_\_\_\_

Time to be given: \_\_\_\_\_

Special instructions for administering the prescribed or 'over the counter' medication (e.g. must be taken with food or with a glass of water):

\_\_\_\_\_

\_\_\_\_\_

