CONSENT/REQUEST TO DISPENSE MEDICATION

To be completed by Parent or Guardian

My child ________________________________ of ______________________

(Child’s full name) (Class name)
requires the following medication:

Name of medication ________________________________________________

for ________________________________________________________________

(condition/ reason for medication)

Dose/Application: _________________________________________________

(e.g. mls/tablets/drops if applicable)

Frequency/Times: _________________________________________________

Date/s: _____________________________ up to and including ________________

Other relevant information/comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I understand my child must present to the Sick Bay at the specified times for this medication to be administered.

________________________________________________________________________

Parent/Guardian name (please print) _________________________________ Signature _________________________________

Date _______________________________