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