Bethany
Catholic Primary

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NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To be completed by parent or guardian

I request that my child _____ of Class _____ be allowed to take medication at school to instructions from _____

(full name of prescribing doctor)

Name of Medication _____

Dosage Required _____

Frequency _____

Medication to be taken for a period of _____

Teacher has been informed ◯ Yes

Address of prescribing doctor: _____

_____

Contact number: _____

The medication has been prescribed for the following reason:

_____

_____

_____

I hereby give permission to the school to obtain relevant information from the prescribing doctor.
I accept and agree that it is my responsibility to inform the school of any changes involving the administration of the medicine.

Signed: _____ Date:_____

parent/guardian