Hillsmeade Primary School
· Growing and Learning Together ·

MEDICATION REQUEST FORM

	Start	Finish
DATE:		

PARENTS NAME:

ADDRESS:

TELEPHONE
(Business Hours)

Dear Principal

I request that my child______________________________________ Class_________
(Child's Name)
Be administrated the following medication whilst at school, as prescribed by the child's medical practitioner.

NAME of MEDICATION

DOSAGE (Amount):

TIME:

I have sent the medication in the original container displaying the instructions provided by the pharmacist for this short term medication

OR

The necessary information and known side-effects regarding this long term medication is attached.

Yours sincerely

- -

(Parent's Signature)

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