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