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