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