MARKET FIELD SCHOOL

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Pupil's Full Name: …… Class: ……

Address: ……

……

Condition/Illness: ……

How long will your child be required to take the medicine? ……

The time(s) your child required medicine in school ……

Amount required ……

Date dispensed ……

Additional instructions/information (e.g. before/after food, interaction with other medicines, possible side effects, storage instructions)

……

……

……

Other medications taken and times taken ……

EMERGENCY CONTACTS

Name: …… Relationship to Child ……

Daytime Tel. No. ……

I understand that the medicine must be delivered to the School Office.

Name: …… Relationship to Child ……

Signed …… Date ……

Playleader's Signature: …… Name: …… Date: ……

SCHOOL USE

Remaining medicine returned to parent on date : ……