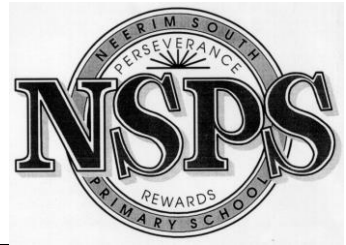


MEDICATION REQUEST FORM



DATE:	/ /
PARENT'S NAME:	
PHONE (School hours):	
MOBILE:	

Dear Principal/OSHC Coordinator,

I request that my child _____ be administered the Medication detailed below whilst at school/outside school care 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 instruction provided by the pharmacist and understand that this will be kept in sick bay at School.

Parent Signature: _____

Office use only

Approved:	
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DATE	TIME	SIGNATURE

