PHOENIX PRIMARY SCHOOL

PARENTAL REQUEST FOR ADMINISTRATION OF MEDICINE IN SCHOOL

NAME OF CHILD ……

DATE OF BIRTH ……..

CLASS ……

ADDRESS ……..

PARENT TEL NUMBER ……

EMERGENCY NAME/NUMBER ……..

1. ……

2. ……

G.P NAME/CONTACT NUMBER

……

MEDICAL CONDITION

……

SYMPTOMS

……

ACTION TO BE TAKEN

……

……

NAME OF MEDICATION ……

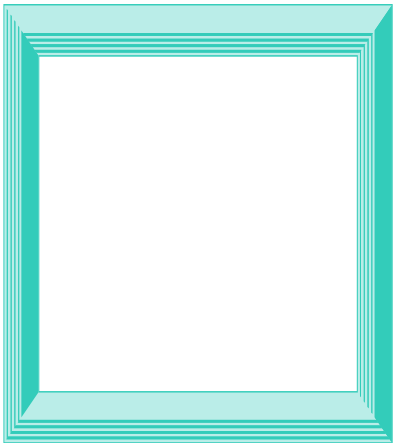
DOSAGE AND TIME TO BE ADMINISTERED

……

SIDE EFFECTS IF ANY

……..

……..



ALL MEDICATION SENT TO SCHOOL MUST:

- Be in original container
- Be labelled with child's name
- Be labelled with strength and name of medication.
- Have a clear expiry date

I require school staff to administer my child's medication. I have completed all written records required by the school. I agree to the procedures listed in the Phoenix School Medical Policy.

Name (print).....

Name(sign).....

Relationship to child.....

Date