Scarborough Public School

Quality Teaching in a Caring, Creative Environment

Request for administering prescribed medication to the student

(*Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication*.)

Student Name_____ Date_____

Name of prescribed medication: .....

Prescribed for (name of medical condition):.....

Prescribed dosage:…… Time:……..

What are you requesting the school to do?.....

.....

Special storage requirements if any eg in refrigerator: .....

Special instructions for administering the prescribed medication/s eg must

be taken with food or with a glass of water: .....

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

Yes ☐ No ☐ If Yes, Please provide more information:

.....

If your child administers his or her own medication at home, do you request

that he or she self administers this medication at school?

Yes ☐ No ☐

(Note: *The Principal needs to approve a decision for a student to self administer*).

If your child self administers the medication at home, what level of support

do you provide? (Please describe): .....

Name of person who will carry the medication to school: .....

Parent/Carer Signature……Date…….

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