Notification and Request by Parent/Guardian
for the administration of medication during school hours

be completed by the parent or guardian

I request that my child ___________________________ in class _________ be allowed to
take medication at school according to instructions from __________________________
(full name of prescribing doctor)

Address of prescribing doctor: ____________________________________________
________________________________________________________________________

Contact number: _________________________________________________________

The medication has been prescribed for the following reason:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I hereby give permission to the Principal to obtain relevant information from the
prescribing doctor. I accept and agree to observe the conditions imposed by the school and
understand and agree that it is my responsibility to inform the Office Staff of any changes
involving the administration of the medicine.

Signed: ___________________________ Date: _________________________
(Parents/Guardian)