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

SCHOOL NAME and ADDRESS: _____

STUDENT NAME: _____ Gender: _____

DATE OF BIRTH/YEAR LEVEL: _____

……

Please identify the medication (prescribed or 'over the counter') that the student requires during school hours including any emergency medication.

Name of prescribed medication: _____

Dosage (e.g. 5 mg) and Route of administration (e.g. oral, by injection):

_____

Time to be given: _____

Special instructions for administering the prescribed or 'over the counter' medication (e.g. must be taken with food or with a glass of water):

_____

_____