MEDICATION REQUEST FORM

FAMILY NAME:__________________________________________

I hereby authorise a representative of St. James' Primary School to administer or to supervise the administering of the medication in accordance with the instructions specified below.

Name of child: ___________________________ Grade: ________________

Name of Medication: _____________________________________________

Form of Medication: (eg. tablet, liquid, etc.) __________________________

Date(s) on which medication is to be administered _______________________

Amount of Medication to be administered: ____________________________

Time(s) at which the medication is to be administered:

_________________________________________________________________

Please note that NO MEDICATION will be administered without the appropriate form being fully completed.

It is the responsibility of the parent or guardian to keep information current and accurate.

Signature of Parent or Guardian: ________________________________

Date: _____ / ____ / _____