REQUEST TO ADMINISTER MEDICATION TO MY CHILD WHILE IN THE CARE OF THE SCHOOL LONG TERM



(Note: Medication must be provided by parents/carers)

STUDI	ENT'S NAMI	E:					
DOB:			ROOM	ROOM/YEAR:			
NAME	OF MEDICA	ATION:					
DOSE (MAYBE		RMACIST'S LABEL)		TIME(S) TO BE ADMINISTERED:			
	E OF ADMIN MOUTH)	IISTRATION:					
EXPIR	Y DATE OF	MEDICATION:					
DATES of ADMINISTRATION:			FROM:		то:		
STOR	AGE REQUI	REMENTS: (E.G. REFRIGE	ERATOR)				
PARENT/CARER SIGNATURE:				DA		:	
Fo	orm 12 - R	ECORD OF HEALTH (CARE SU	PPORT/AD	MINISTRATION	I OF MEDICATION	
Name: Date of Birth			Year: Room:		Teacher:		
	REC	ORD OF HEALTH CARI	E SUPPOR	RT/ADMINIS	TRATION OF ME	DICATION	
Date Time Support/Medica			cation/Dos	е	Staff Member	Signature/Initials	

Form 12 - RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION Name: Date of Birth Year: Teacher: Room: RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION Time Support/Medication Staff Member Signature/Initials Date Record from: / / to: / / Date: / / Signed: ___ PAGE 2 OF 2

