



# Scarborough Primary School

An Independent Public School

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

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

<b>STUDENT'S NAME:</b>	
<b>DOB:</b>	
<b>YEAR:</b>	
<b>ROOM:</b>	
<b>NAME OF MEDICATION</b>	
<b>DOSE/FREQUENCY (MAYBE AS PER PHARMACIST'S LABEL)</b>	
<b>ROUTE OF ADMINISTRATION (E.G. BY MOUTH)</b>	
<b>EXPIRY DATE OF MEDICATION:</b>	
<b>DATES OF ADMINISTRATION:</b>	<b>From:</b> _____ <b>To:</b> _____
<b>STORAGE REQUIREMENTS: (E.G. REFRIGERATOR)</b>	
<b>NAME OF ADMINISTRATOR:</b>	<b>Administration Staff</b>
<b>PARENT/CARER SIGNATURE:</b>	
<b>DATE:</b>	