GALILEE REGIONAL CATHOLIC PRIMARY SCHOOL
MEDICATION REQUEST FORM

This medical form must be filled out and signed by the parent/guardian. Please print carefully.

This form will be valid for 5 school days only.

All medication must be given to the school office. All medication must be labelled with the child's name, the dosage as well as when and how it should be taken.

START DATE: ______ **END DATE:** ______

STUDENT NAME: ______ **CLASS:** ______ **DOB:** ______

PARENT/GUARDIAN NAME: ______ **PARENT/GUARDIAN CONTACT NUMBER:** ______

Dear Principal,
I request that my child be administered the following medication whilst at school, as prescribed by the child's medical practitioner.

NAME of MEDICATION: ______

DOSAGE (AMOUNT): ______

TIME: ______

Yours sincerely

______________ ________________ ________
(Parent name) (Parent Signature) (Date)

Date					
Time/s					
Administered by					
Witnessed by					