



FORM 1

NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTERING OF MEDICATION DURING SCHOOL HOURS

To be completed by parent or guardian

I give permission for my child _____ (full name of student)

Learning Studio: _____

to take medication at school according to instructions from:

Prescribing Doctor: _____

Address of prescribing doctor: _____

Doctors Contact number: _____

NAME OF MEDICATION: _____	
DOSAGE: (ml / tablet) _____	
TIME/S REQUIRED: _____	
FROM DATE: _____	TO DATE: _____

The medication has been prescribed for the following reason:

I hereby give permission to the Principal to obtain relevant information from the prescribing doctor.

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administering of the medicine.

Signed: _____ Relationship: _____ Date: _____
Parent/Guardian *Mother/Father*