St Francis of Assisi
Glendenning

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

To be completed by parent or guardian

I request that my child _____ be allowed to take medication at
Student's full name

school according to instructions from:

Name & Address of prescribing doctor: _____

_____

Contact number: _____

Name of Medication:

_____

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 administration of the medicine.

Signed: _____ Date:_____
Parent/guardian