



SUNNYHILL PRIMARY SCHOOL - REQUEST TO ADMINISTER MEDICINE

Please complete this form if you wish the school to administer medication to your child/ren or supervise them whilst they take the medicine themselves during the school day.

This form will be kept in the office and class teacher will be provided with a copy:

Child's Name				
DOB		Class		
Condition/ Illness				
Medicine Name		Expiry Date		
To be stored in:	Medicine fridge		Medicine Cabinet	
Dosage				
Time/s of dosage				
<i>Please indicate (with a ✓) which days you wish the school to administer the medicine</i>				
(Mon)	(Tue)	(Wed)	(Thu)	(Fri)
Duration of Administration:		Self- administration:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Side effects:				
Emergency Contact Name		Number		

Parent Signature		Date	
Parent (Print Name)			

OFFICE ONLY:

Name of Receiving Officer:		Date of receipt:	
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