



## SUNNYHILL PRIMARY SCHOOL REQUEST TO ADMINISTER MEDICATION

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)				
Staff Name (completing form)				

Class Copy  Office Copy