ST MICHAEL'S CE JUNIOR SCHOOL
REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Please complete and bring in to the school office with the medication clearly labelled

CHILD'S NAME	
CLASS	
NAME OF MEDICATION	
DOSAGE (HOW MUCH)	
FREQUENCY (HOW OFTEN)	
TO BE GIVEN (PLEASE CIRCLE)	**BY MOUTH / BY INHALATION / APPLIED TO SKIN / EAR DROPS / EYE DROPS** **PLEASE STATE ANY PRECAUTIONS OR POSSIBLE SIDE EFFECTS:**
SIGNATURE OF PARENT/CARER:	
DATE:	

All medications are given at lunchtime. Please state if the medication should be given at any other time