

St Joseph the Worker School

Request for school to administer medication

Pupil's Full Name: Class.....

Address

Condition/Illness

Name/Type of medication

For how long will child be required to take medication

Date treatment started Frequency of Dosage Timing

Additional instructions/information

Emergency Contact:

Name Relationship to child

Phone number

I understand that I must deliver the medicine personally to the office staff and collect any remaining medication when the course is completed. I accept that the school has a right to refuse to administer medication

Name

Signed Date