MARY IMMACULATE

learning today ... leading tomorrow

Date: ________________________

Dear Principal,

RE: Notification and request for the administration of medication during school hours.

I request the school administer prescribed medication at school, during school hours, to my son/daughter ______________________________of class_________________ according to the following medication details.

Students on medication for Asthma, ADHD, and Anaphylaxis require a letter from their doctor specifying the dosage of prescribed medication.

Student's Name: ______________________________

Prescribing Doctor: ______________________________

Medical Condition Requiring medication: ______________________________

Medication: ______________________________

Period of treatment: From: ________________ To: ________________

Dosage: ______________________________

Times of administration: ______________________________

Special Instructions: ______________________________

Self Administered: Yes ☐ No ☐

I/We accept and agree to observe the conditions imposed by the school and understand and agree that it is my/our responsibility to ensure that all medication given has a valid expiry date and will inform the Principal of any changes involving the administration of the medicine.

Yours sincerely,

Parent/Guardian Name: _______________________________________

Parent/Guardian Signature: _____________________________________

The ongoing administration of medication requires this form to be replaced every calendar year. For students on Ventolin, Epi-pen and ADHD medication, it is recommended by the Children's Hospital that a doctor should review the condition at least every twelve months. Please record expiry dates of your child's medication and replace as required.

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