



# CHRIST THE KING SCHOOL

## REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

I/We wish to inform you that it is necessary for my/our child, \_\_\_\_\_ to have medication at school. I/We therefore request, through the person(s) responsible appointed by the Principal, to have the medication listed below administered to my/our child. I/We agree to provide a supply of the medication in the Pharmacy's container, providing the following details clearly marked on the container:

1. Name of Child \_\_\_\_\_
2. Name of Medication \_\_\_\_\_
3. Quantity of medication to be administered. \_\_\_\_\_

Name of Parent/Guardian: ..... Phone Number: .....

Signature of Parent/Guardian: ..... Date : .....

**PLEASE PRINT IN BLOCK LETTERS THE FOLLOWING DETAILS:**

Student Name:.....

Class: .....

Condition: .....

Name of Medication: .....

Are special arrangements necessary to administer the drug or monitor the student after drug administration? YES NO If yes give details .....

Quantity/Method of Administering Medication: .....

Duration of need for Medication (eg. specific dates/term/)

.....

Prescribing Doctor (Print Name): ..... Phone Number: .....

Signature of Prescribing Doctor signature: ..... Date: .....

.....

**OFFICE USE ONLY**

Time	Date	Dosage	Administered By	Initials	Checked	Initials

***TIME DATE DOSAGE ADMINISTERED BY INITIALS CHECKED INITIALS THIS PERMISSION FORM IS VALID FOR THE DURATION OF TREATMENT UNLESS THERE IS PERMANENT MEDICATION (eg: ALLERGIES) IN THAT CASE, PERMISSION FORM IS VALID FOR ONE SCHOOL YEAR ONLY.***