Prescribed Medications Form

Student Name: _____ Class: _____

Parent/Carer Name: _____

Mobile No: _____

Work No: _____

Home No: _____

Doctor's Name: _____

Doctor's No: _____

Name of Medication: _____

Time to be medicated: _____

Dose of Medication: _____

Period for which medication will be needed at school: _____

_____

Instructions for administering medication, e.g. must be taken with food/water:

_____

Reason for which mediation is required, e.g. medical condition:

_____

Storage requirements, e.g. must be refrigerated: _____

_____

Special instructions: _____

_____

Note: For student safety, all medications must be delivered to the office by an adult.

_____ _____

Parent/Carer Signature Date