WESTGATE PRIMARY SCHOOL AND CHILDREN'S CENTRE

Request for school to Administer Medication

Details of Pupil

Child's Full Name____ Class______________________

Address____ Date of Birth_________________

Condition or Illness____

Medication

Name/Type of Medication [as described on the containef]:_______________________________________

Date Dispensed____________________________________ Expiry Date:______________________________

Full Directions for Use

Dosage [As per instructions on the container]: ____

______________________________________ Before or After Lunch ________________________________

Contact Details

Name: ____

Daytime Telephone Number: ____

Relationship to Pupil: ____

Address [if different from above]: ____

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I understand that i must deliver the medication personally to the office staff and accept that this is a Service which the school is not obliged to undertake.

Signed: ____ Date: ______________________________