SACRED HEART CATHOLIC SCHOOL
REQUEST FOR ADMINISTRATION OF MEDICINE

Name: …….. Class: …….

G.P.: ……. Phone No: ……..

MEDICINE TO BE GIVEN:

Dosage and Method: ……

Time: ……

Side effects: ……..

Any special instructions: ……

……..

I would like a member of staff to administer on my behalf the above medicine, I accept that they are acting on my instructions and they cannot be held responsible if the medicine is not given or given wrongly.

I will inform the school immediately if there is any change in the dosage or frequency of the medicine.

Parent/Guardian Signature: ……Date:……..

Record of Administration – To be completed by school only

	Date	Time	Dose	Sig.		Date	Time	Dose	Sig.
1					10				
2					11				
3					12				
4					13				
5					14				
6					15				
7					16				
8					17				
9					18				