MEDICAL REQUEST FORM - Non- Prescribed Medications

Name of Child	
Date of birth	
Class	
Name of person completing this form (please print name)	

SECTION 1 – Medication Details

Name of medication and expiry date	
The reason for this medication?	
Does this medication contain aspirin? YES/NO	
If this medication contains paracetamol state the first date your child started taking this medicine IN THIS PARTICULAR EPISODE	
How much medication are you leaving (i.e. 20 tablets, one bottle etc) and where should it be stored?	
Dose needed (i.e 5ml, 10 ml etc)	
Is this medication in the original container and got PIL?	
Time/s you need this to be given to your child	
The last date medicine to be given	
Any adverse reaction we should look out for and action to be taken	

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I give permission for a member of school staff to administer this medication to my child as directed.

Signed parent)	
Date	

IT IS PARENTS RESPONSIBILITY TO COLLECT THIS MEDICINE FROM THE OFFICE AT THE END OF THE DAY.

SECTION 2 – Administration Details

Date	Time	Amount Given	Administered by	Returned to adult