St Clare's Catholic High School

A Catholic school of excellence and improvement

NOTIFICATION & REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

I request that my child _____ be allowed to take medication at school according to instructions from _____.
(full name of prescribing doctor)

Address of prescribing doctor: _____
_____
_____

Contact number: _____

The medication has been prescribed for the following reason:

_____

_____

_____

I hereby give permission to the Principal to obtain relevant information from the prescribing doctor. I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Assistant Principal of any changes involving the administration of the medicine.

Signed: _____Date: _____
(parent/guardian)

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