REQUEST TO ADMINISTER MEDICATION TO MY CHILD WHILE IN THE CARE OF THE SCHOOL	
STUDENT'S NAME: DOB: FORM/CLASS	
NAME OF MEDICATION	
DOSE/FREQUENCY (MAYBE AS PER PHARMACIST'S LABEL)	
ROUTE OF ADMINISTRATION (E.G. BY MOUTH)	
EXPIRY DATE OF MEDICATION:	
DATES of ADMINISTRATION:	FROM: / / 200_ TO: / /200_
STORAGE REQUIREMENTS: (E.G. REFRIGERATOR)	
NAME OF ADMINISTRATOR:	
PARENT/CARER SIGNATURE:	DATE: