Australian International School

REQUEST TO ADMINISTER MEDICATION FORM

Student's name: _____ Class: _____ Date: _____

Medication 1: _____

Dose: _____ Route: _____

Dose due: _____

Reason: _____

Medication 2: _____

Dose: _____ Route: _____

Dose due: _____

Reason: _____

Prescribing doctor _____ Phone _____ Medication supplied ☐ Yes ☐ No

I understand that I am responsible for:

- Safely delivering **in-date** medication in **original** containers which are clearly labelled with the student's name, medication name and dosage. Non-prescription medications need the product information supplied. All information must be in English.
- Informing and, in some instances, providing verification of changes in medication.
- Renewing and up dating the request annually, if necessary.

I am aware that details of this medication may need to be discussed with members of the teaching staff.

Signature: _____ Parent / Guardian

Name in print: _____ Telephone: _____

Date	Right student	Right time	Right medication	Right dose	Right route	Staff signature	Witness Nurse = Medication remaining