Holy Family School

ADMINISTRATION OF MEDICATION TO STUDENT REGISTER

Student Name: _____ Class: _____

Name of Medication: _____

Name of Doctor: _____ Phone: _____

Method of Administering the Medication: _____

DOSAGE	TIME	DATE	PERSON WHO ADMINISTERED MEDICATION	WITNESSED BY
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ADMINISTRATION OF MEDICATION PARENT CONSENT FORM

TO BE COMPLETED BY PARENT/GUARDIAN

Please give my child: _____ Class: _____

The following medication as directed by his/her medical practitioner

Name of Doctor: _____

Name of Medication: _____

Dosage: _____

Time/s to be given to student: _____

Method of administering the medication:

_____

Name of Parent or Guardian requesting the medication administration:

_____

Contact Phone numbers: (h) _____ (w) _____ (m) _____

Signed: _____

Date: _____

Please provide any further details below where necessary:

_____

_____

_____

_____