Lyndale Greens Primary School
Student Medication Form

DATE:

PARENT's NAME:

ADDRESS:

TELEPHONE:

Home: Mobile:

Business Hours:

Dear Principal,

I request that my child _____ be administered the following medication
(Child's Name)
whilst at school, as prescribed by the child's medical practitioner.

NAME of MEDICATION:

DOSAGE (AMOUNT):

TIME/S of MEDICATION:

How dosage is to be taken (e.g. orally):

How medication is to be stored: (e.g. refrigeration)

Doctor's name and Location

I have sent the medication in the original container displaying the instructions provided by the pharmacist.

Yours sincerely

_____
(Parent Signature)