Medication Administration Request Form

I ________________________________ being the Parent/Guardian of student ________________

Request that MATER DEI COLLEGE supervise the administration of the following medication for the purpose of treating (condition) ____

PRESCRIBED MEDICATION

Name of medication: ____

Dose: __________________________ Time to be taken: _________________________________

Date medication to be ceased: ____

And/or

NON-PRESCRIPTION MEDICATION

Name of medication: _______________________________________ (supplied by parent/guardian)

Dose: __________________________ Time to be taken: _________________________________

Date medication to be ceased: ____

Comments: ____

____

____

Parent/Guardian Name: _______________________________

Parent/Guardian Signature: _______________________________

Date: _______________________________