LAURANCE HAINES SCHOOL

MEDICATION REQUEST FORM

CHILD'S NAME _____

CHILD'S CLASS _____

THIS SECTION TO BE COMPLETED BY THE CHILD'S PARENT/GUARDIAN

MEDICAL CONDITION	
MEDICATION NAME	
ALLERGIES?	
DATE THIS MEDICATION STARTED (IF FIRST TIME TAKING IT)	
DOSAGE AND TIMING	
NEED TO CHECK TIME OF PREVIOUS DOSE (NON-PRESCTIPTION MEDS)?	
TO BE KEPT IN FRIDGE?	
DATES REQUIRED	
PARENT'S SIGNATURE	

DETAILS OF MEDICATION ADMINISTERED BY STAFF

STAFF NAME	DATE	TIME	DOSAGE	NOTES

STAFF NAME	DATE	TIME	DOSAGE	NOTES