St James Primary School

51 Centre Road, Vermont 3133
Phone: 9874 1830 Fax: 9872 4968
Email: principal@sjvermont.catholic.edu.au

MEDICATION REQUEST FORM

FAMILY NAME:_________________________________

I hereby authorise a representative of St. James' Primary School to administer or to supervise the administering of the medication in accordance with the instructions specified below.

Name of child: ______________________________**Grade:** ________________

Name of Medication: ____

Reason for Medication____

Form of Medication: (eg. tablet, liquid, etc.)_____________________________

Date(s) on which medication is to be administered_______________________

Amount of Medication to be administered:______________________________

Time(s) at which the medication is to be administered:

____

Please note that **NO MEDICATION** will be administered without the appropriate form being fully completed.

It is the responsibility of the parent or guardian to keep information current and accurate.

Signature of Parent or Guardian: _____________________________________

Date:______/_____/______