St. Michael Catholic School
Pupil Medication Request

Name of Child …….. Class ……..…….

Condition or Illness …….. Date ……..

Home Telephone …….. Mobile ……..

Name of Medicine	Dose required	Time to be given	Date for completion course	Expiry date of medication

- I agree to members of staff administering medicines/providing treatment to my child as directed above or in the case of an emergency, as staff consider necessary.
- Medicines should be brought to and collected from the Front Desk by parents or another responsible adult.
- Medication should be in the original prescribed bottle/packaging.

Signed (Parent/Guardian) …….. Date……

NOTE: Where possible the need for medicines to be administered at school should be avoided. Parents are therefore requested to try to arrange the timing of doses accordingly.

DATE	TIME	NAME OF MEDICINE	DOSE GIVEN	STAFF SIGNATURE	STAFF NAME