ELMHURST

Date:

Student's Full Name:

Class:

Date of Birth:

Details of condition requiring medication:

PRESCRIBED MEDICATION

Medication Name:

Date of Prescription:

Dosage Amount:

Time(s) to be given:

Number of days:

NON PRESCRIBED MEDICATION

Medication Name:

Dosage Amount:

Time(s) to be given:

Number of days:

I authorise the medical team at Elmhurst School to administer the below named medicine(s) to my child at the times stated.

Signature:

Parent's Full Name:

TO BE COMPLETED BY MEDICAL STAFF:

Medicine given: ☐
Date:
Time:
Administered by:

Medicine given: ☐
Date:
Time:
Administered by:

Medicine given: ☐
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Administered by:

Notes: