CLAYFIELD COLLEGE
Medication Request Form

DATE: _____

PARENT/GUARDIAN'S NAME: (Mr, Mrs, Ms Dr) _____

CONTACT TELEPHONE NO: _____

CHILD'S NAME: _____ **YEAR LEVEL:** _____

DOCTOR'S NAME: _____ **TELEPHONE NO:** _____

PERIOD OF MEDICATION: _____

NAME OF DRUG/MEDICATION: _____

DOSAGE: _____

TIME OF DAY MEDICATION TO BE ADMINISTERED: _____ am _____ pm

REASON/PURPOSE OF MEDICATION: _____

_____

(Please note: Container must be clearly marked with the child's name, dosage and instructions for dispensing.)

Whilst Health Centre Staff are prepared to assist in this matter, the ultimate responsibility rests with the parents.

Signature: _____
(Parent/Guardian)