



## Form 1

**Notification and Request by Parent/Guardian  
for the administration of medication during school hours**

**be completed by the parent or guardian**

I request that my child \_\_\_\_\_ in class \_\_\_\_\_ be allowed to take medication at school according to instructions from \_\_\_\_\_  
(full name of prescribing doctor)

**Address of prescribing doctor:** \_\_\_\_\_  
\_\_\_\_\_

**Contact number:** \_\_\_\_\_

The medication has been prescribed for the following reason:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby give permission to the Principal to obtain relevant information from the prescribing doctor. I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Office Staff of any changes involving the administration of the medicine.

Signed: \_\_\_\_\_  
(Parents/Guardian)

Date: \_\_\_\_\_