MEDICAL ADMINISTRATION FORM

Notice for parents to complete for the administration of medicines.
Note, this does not have to be completed by children requiring asthma medication unless specified in the child’s Asthma Management Plan.

MY CHILD ___________________________ GRADE ______

REQUIRES THE ADMINISTRATION OF ___________________________
(name medicine here)

AT ___________________ (time)

FOR THE DURATION OF ___________________________
(how many days ie. one week; until medicine exhausted; for the remainder of the year).

THE DOSAGE IS ___________________________
(please include how often ie. twice a day, after eating etc.)

OTHER IMPORTANT DETAILS ___________________________

SIGNED ___________________________

DATE ___________________________