



SAMUEL GILBERT PUBLIC SCHOOL

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LONG TERM MEDICATION FORM

Child's Name _____ Class _____

Reason for Medication _____

Special instructions / possible side effects _____

Days Required	Medication Name	Dosage	Time to be Administered	Administered By
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

All medication to be supplied in measured daily doses in a secure container. The container must be clearly labelled with students name and class

TO BE COMPLETED BY PARENT / CAREGIVER

I request that my child _____ of class _____ be administered the above mentioned medication as per instructions provided. A copy of the dosage as prescribed by the medical practitioner is attached.

Signed _____ Parent / Caregiver

Print Name _____ Dated _____

TO BE COMPLETED BY PRINCIPAL / DELEGATE

Long term medication request approved? YES / NO

Signed _____ Principal / Delegate

Print Name _____ Dated _____