



SAMUEL GILBERT PUBLIC SCHOOL

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SHORT TERM MEDICATION FORM

Child's Name _____ Class _____

Reason for Medication _____

Special instructions / possible side effects _____

Start Date: _____ End Date _____

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

All medications MUST BE in original pharmaceutical containers so that the school can be certain of the dosages prescribed by your doctor.

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 OR DELEGATE

Short term medication request approved? YES / NO

Signed _____ Principal / Delegate

Print Name _____ Dated _____