

**CERDON COLLEGE MERRYLANDS**

**Aspire to Great Heights**

**Request to Administer Medication to a Student**

This record is to be completed by the parent/carer and, where appropriate, in consultation with their child’s doctor (General Practitioner/Specialist).

**Parents should inform the College immediately if there are any changes to this Medication Request**

**Student’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student’s Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Homeroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Medication Requirements***

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| --- | --- | --- | --- | --- |
| **NAME OF MEDICATION** | **DOSAGE REQURED** | **TIME** | **METHOD OF APPLICATION** | **DATE TO DISCONTINUE**  **MEDICATION** |
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|  |  |  |  |  |

* I authorise Cerdon College to administer medication to my daughter as outlined above.

**Signature of Parent/Carer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**