



MOUNT RIVERVIEW PUBLIC SCHOOL

188-204 RUSDEN ROAD, MOUNT RIVERVIEW, NSW 2774

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EMAIL: mtrivervie-p.school@det.nsw.edu.au

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Request for administering prescribed medication to the student

Name of student:

Name of Doctor:

Name of prescribed medication:

Prescribed for (name of medical condition):

Prescribed dosage: Time to be taken:

Please send in the original medication packaging.

What are you requesting the school to do?

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Special storage requirements if any eg in refrigerator:

Special instructions for administering the prescribed medication eg must be taken with food

or with a glass of water:

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

Yes ☐ No ☐ If yes, please provide more information:

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Parent or Carer signature:

School Representative signature:

Date: