



# St Clare's Catholic High School

*A Catholic school of excellence and improvement*

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## **Notification & Request by Parent/Guardian for the Administration of Medication During School Hours**

I request that my child \_\_\_\_\_ be allowed to take medication at school according to instructions from \_\_\_\_\_.  
*(full name of prescribing doctor)*

**Address of prescribing doctor:** \_\_\_\_\_

\_\_\_\_\_

**Contact number:** \_\_\_\_\_

The medication has been prescribed for the following reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby give permission to the Principal to obtain relevant information from the prescribing doctor. I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Assistant Principal of any changes involving the administration of the medicine.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*parent/guardian*