STUDENT MEDICATION REQUEST and EMERGENCY ACTION PLAN
(CONFIDENTIAL)

I _____ being the parent/guardian of student

_____D.O.B. _____ Class _____
(name)

request that Mary's Mount Primary School supervise the administration of the following medication daily/

in emergency as prescribed by Dr. _____ Phone_____ whose

letter is attached for the purpose of treating_____
(condition)

His/her condition is:	under control, no medication	YES / NO
	under treatment, and is fine	YES / NO
	under constant supervision	YES / NO
	other (indicate below)	

Name of medication: _____
(any medication supplied is to be labelled, named, dated, and have instructions with it)

Dose: _____

Time to be taken: _____

Other treatment & comments: _____

_____

_____

_____

I understand that it is important for me to contact the school in the event of any of the above information being changed.

_____ Date: _____
(Signature of Parent/Guardian)