

MEDICATION FORM

Student's Name: _____ Class: _____ Date: _____

Name of Medication: _____

Dosage & Frequency: _____

Parent's Name: _____ Signature: _____

MIC staff may administer medication/remedies for a student on the following basis:

- Parent/guardian is required to complete this Medication Form.
- Medicines/remedies MUST be clearly marked by a chemist/practitioner with the student's name and dosage on the label. If the medication/natural remedy does not have a label, we are legally not allowed to give it to your child.

STAFF TO COMPLETE

Date	Name of Medication	Dosage	Time Dosage Due	Time Administered	Administered By	Signature	Witnessed by	Witness' Signature

Staff Information:

- ALL medication will be stored in a place not accessible to students.
- Staff should never agree to administer medication or provide medical treatment if they doubt their competency to do so successfully.