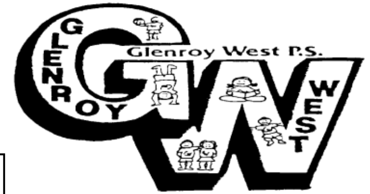
MEDICAL MANAGEMENT PLAN



DATE: / /

CHILD's Name

PARENT's / CARER's NAME:

Place of Residence:

TELEPHONE:
(Business Hours)

(Other contact number)

Dear Principal,

I request that my child ________________________ be administered the following
(Child's Name)
medication whilst at school.

NAME of MEDICATION:

DOSAGE (AMOUNT):

TIME:

I have sent the medication in the original container displaying the instructions provided by the pharmacist and or medical practitioner.

The information collected will only be used for the purpose of management of medication.

Yours sincerely

_________________ (Parent / Carer Signature)