Date:

Home Address:

Dear Principal,

RE: NOTIFICATION AND REQUEST FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

I / We request the school to administer prescribed medication at Holy Trinity School Granville, during school hours, to our son / daughter _____ according to the following medication details.

Student's Name:_____

Prescribing Doctor:_____

Medical Condition requiring medication:_____

Period of Treatment: From_____**To:**_____

Name of Medication:_____

Dosage:_____

Times of Administration:_____

Special Instructions:_____

Self Administered : Yes ☐ **No** ☐

I / We accept and agree to observe the conditions imposed by Holy Trinity School Granville and understand and agree that is my / our responsibility to inform the Principal of any changes involving the administration of the medicine.

Yours sincerely,