

**Form 4: School acknowledgment of agreeing to administer medication**

As per your request, dated ....., the school governing body and management of ..... (name of school) agree to administer medication to .....(learner) according to the script received from Dr.....

This comprises the following medication/s

- Medication 1 .....Dose ..... Times ..... Period .....
- Medication 2 .....Dose ..... Times ..... Period .....
- Medication 3 .....Dose ..... Times ..... Period .....
- Medication 4 .....Dose ..... Times ..... Period .....
- Medication 5 .....Dose ..... Times ..... Period .....
- Medication 6 .....Dose ..... Times ..... Period .....

until instructed by the parent/guardian or medical practitioner in writing.

Name of teacher/school personnel member responsible: .....

Proxy should this personnel member be absent: .....

Signed: ..... Date: .....  
(Member of Chronic Illness Action Committee)

Signed: ..... Date: .....  
(Principal)

Signed: ..... Date: .....  
(School personnel member responsible)

Signed: ..... Date: .....  
(Proxy)