Sacred Heart Catholic School

NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To be completed by parent or guardian

I give permission for my child _____be administered medication at

(full name of student)

school according to instructions from _____.

(full name of prescribing doctor)

Name of Medication _____.

Dosage _____.

Time to be given _____.

The medication has been prescribed for the following reason:

_____

_____.

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medicine.

Signed: _____ Date:_____

parent/guardian

9 Church Street Coolah, NSW 2843 Telephone: 02 6377 1132 Facsimile: 02 6377 1458
Email: sacredheartcoolah@bth.catholic.edu.au