Parkwood Green Primary School

Medical Consent Form

DATE:

STUDENT's NAME:

STUDENT's CLASS:

PARENT's NAME:

PARENT's TELEPHONE:
(Business Hours)

I request that my child be administered the following medication/s whilst at school, as prescribed by the child's medical practitioner.

NAME of MEDICATION(S)	DOSAGE (AMOUNT)	TIME

I have sent the medication/s in the original container displaying the instructions provided by the pharmacist or manufacturer.

Yours sincerely _____
(Parent Signature)

MEDICATION ADMINISTERED	DOSAGE ADMINISTERED	DATE & TIME	SIGNATURE OF PERSONEL WHO ADMINISTERED MEDICATION