Coffs Harbour Christian Community School

Medication Consent Form

Our records show that your child may require medication whilst at school. Even if you have supplied this information already, please complete this form and return it to the Front Office. Please complete a separate form for each child.

Surname (Family name): _____

Given name(s): _____

Date of Birth: _____ Year level/Class: _____

Emergency contact (Parent/Guardian):

Name and relationship: _____

Telephone Number: _____

Student's local doctor:

Name: _____

Telephone Number: _____

Medication

Medical condition requiring medication:

_____

Please describe the **signs and symptoms** of the medical condition:

_____

_____

What action is required?

_____

_____

Name of medication required:

_____

Medication Dosage: _____ Device used: _____

Medication start date:_____ Medication end date:_____

Please Note: **Medication MUST be supplied by you.** It will be stored in our locked First Aid cabinet or fridge as required.

Parent/Guardian signature: _____ Date: _____