



Medication Consent Form

If your child requires medication administered when at school, please complete this form and return it to Student Reception (by email or in person).

Please complete a separate form for each child and/or medication required.

Surname/Family name:

Given name(s):

Date of Birth:

Year level:

Emergency contact(s)

Name and relationship:

Telephone Number:

Student's local doctor

Name:

Telephone Number:

Details of Medication Required:

Medical condition requiring medication:

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

What action is required?

Name of medication required:

Medication Dosage:

Start Date:

Device used:

End date:

Please Note:

Medication MUST be supplied by you.

All medications should be delivered to Student Reception and will be stored in our locked First Aid cabinet or fridge (as required). Your child must attend the school office/sick bay for medication to be administered.

Parent/Guardian signature: _____ Date: _____