MEDICATION FORM

TO BE COMPLETED AND SENT TO SCHOOL IF YOUR CHILD IS TO BE ADMINISTERED WITH ANY MEDICATION WHILST AT SCHOOL

My Child _____

is currently required to have the following medication/s:
Full Name of Medication/s:

_____ Dose: _____ Time/s: _____

_____ Dose: _____ Time/s: _____

PLEASE NOTE:
All medication is to be handed to the office or supervising teacher.
NO MEDICATION IS TO BE KEPT BY STUDENTS.

_____ _____

Parent/Guardian Date

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