

Sacred Heart



Primary School

29 Murphy Street, Pearce ACT 2607

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2014

CONSENT/REQUEST TO DISPENSE MEDICATION

To be completed by Parent or Guardian

My child _____ of _____
(Child's full name) (Class name)

requires the following medication:

Name of medication _____

for _____
(condition/reason for medication)

Dose/Application: _____
(e.g. mls/tablets/drops if applicable)

Frequency/Times: _____

Date/s: _____ up to and including _____

Other relevant information/comments:

I understand my child must present to the Sick Bay at the specified times for this medication to be administered.

Parent/Guardian name (please print)

Signature

Date