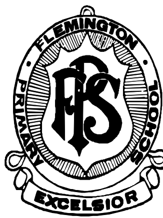

Flemington Primary School

Mt Alexander Road (PO Box 7), Flemington 3031
Telephone: 9376 7137 / Facsimile: 9376 2230

CONSENT FOR MEDICATION

NAME OF CHILD:
GRADE:

Please provide details of medication, dosage, times, etc.

Medication: ______________________________

Dosage: ______________________________

Times: ______________________________

Comments: ______________________________

____

Please note that ALL medicines are to be clearly labelled with your child's name and required dosage of medication.

I consent to school staff supervising the administering of the above medicines to my child.

Signed:
…………………………………………………………………………………………..
(Parent / Guardian)

Date: ……………………………………………

Office Use Only

Medication Administered

Date	Time Administered	Administered by (name)	Signature