Administration of Regular Prescribed Medication

Dear Parents,

Please complete this form for any prescribed, regular medication that is to be administered to your child during school hours and return it to Reception.

Student Name: Class:

Name of Medication/s to be Administered: Dose: Time/s:

Name of Medication/s to be Administered: Dose: Time/s:

Medication needs to be refrigerated?

(please circle) Yes / No

Extra Notes:

Parents Name:

Parent Contact No:

Parent Signature:

Date:

- Please note that this form is not to be used for consent of over the counter medications such as Paracetamol or Antihistamines.
- Should any changes occur to the medication throughout the school year please notify the College First Aid Officer.