PERMISSION VALID FOR ONE WEEK ONLY

CHILD’S NAME:_______________________________    CLASS:  _________     DATE:  ___/___/___
PARENT/CAREGIVER:_______________________________________________________________
PHONE NUMBER IF CONTACT IS NECESSARY:  _____________________
ALTERNATIVE PHONE NUMBER:  ____________________

DOCTOR’S INSTRUCTIONS

PERIOD OF MEDICATION – THIS FORM COVERS ONE WEEK.

NAME OF DRUG/MEDICATION_________________________________  DOSAGE:  _____________
TIME OF DAY MEDICATION IS TO BE ADMINISTERED __________am  __________pm.

PLEASE NOTE:

 CONTAINER MUST BE THE ORIGINALLY DISPENSED CONTAINER, WHICH IS LABELLED WITH THE
CHILD’S NAME, DOSAGE AND INSTRUCTIONS FOR DISPENSING. PLEASE SUPPLY A MEASURING CUP.

WHILE STAFF MEMBERS ARE PREPARED TO ASSIST IN THIS MATTER, THE ULTIMATE RESPONSIBILITY
RESTS WITH THE PARENT.

Signature______________________________ (Parent/Caregiver)

MEDICATION DURING SCHOOL HOURS

At times it is necessary for children under doctor’s instructions to take medication during
school hours. We are aware of this need and are willing to assist you in this situation.
However, for the safety of the child, it is of utmost importance that the following form be
completed in full. Administrative staff at a centralised location in the Administration Block will
administer all medication.

Thanking you for your co-operation.

Principal