



SACRED HEART SCHOOL BOGGABRI

Short Term Administration of Medication at School

**NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE
ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS**

This is a reminder that the School's Administration of Medication Policy and Anaphylaxis Policy requires the following information to be completed by the Parent/Guardian

I request that my child:

Full Name of Student

be allowed to take medication at school according to instructions from:

Full name of Prescribing Doctor

Address & Phone number of Prescribing Doctor

The medication has been prescribed for the following reason:

I hereby give permission to the Principal to obtain relevant information from the Prescribing Doctor.

Name of Medication: _____
(all medication must be in original packaging)

Dosage to be given: _____

Time(s) to be given: _____

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medication.

Signed: _____
Parent/Guardian

Date: _____