ST MATTHEW'S PRIMARY SCHOOL

Stutchbury Street, Page ACT 2614 PO Box 4172, Hawker ACT 2614

CONSENT/REQUEST TO DISPENSE MEDICATION

To be completed by Parent or Guardian

My child ______________________________ of ____________________

(Child's fulll 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:

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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