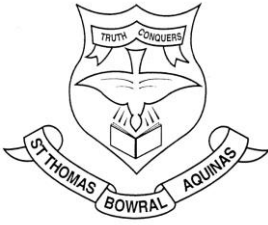


ST. THOMAS AQUINAS CATHOLIC PRIMARY SCHOOL



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CONSENT TO DISPENSE MEDICINES

Notification And Request By Parent/Guardian For The Administration Of Medication During School Hours

To be completed by Parent or Guardian

I request that my child:

_____ (*Full Name of Student*) of Class _____

be allowed to take be given _____

(*name of medication*) at school in dosages of _____

At _____ (*times*) according to instructions from:

_____ (*Full name of Prescribing Doctor*)

_____ (*Address and 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 and/or to convey my child to the local hospital by appropriate transport which may be ambulance. *

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 medicine.

Signed:

Parent/Guardian: _____ Date: _____

* Ambulance costs for travel from school to the hospital are covered by the school