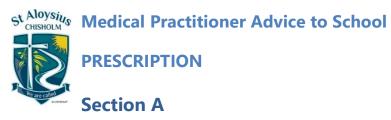


PARENT REQUEST for Administering Prescribed Medication (Schedule 4 & 8) to a Student.

PRESCRIPTION

(To be complete by parent / guardi	an)
I	request that my son/daughter
of classbe allowed to	o take medication at school under adult supervision according
to instructions from:	
Prescribing Doctor:	
Address:	
Phone	
I accept and agree to observe the cond	otain relevant information from the Prescribing Doctor. ditions imposed by the school and understand and agree that ncipal of any changes involving the administration of the
Signed:(Parent/Guardian)	Date:



(To be completed by the parent/guardian)

The Principal of	al ofSc		hool seeks information which would assist the staff of St		
Aloysius Catholic	Primary School in ac	dministering medica	tion to my child		
hereby give my	permission for the n	ecessary information	n to be supplied to th	e school.	
		•	• • • •	al of the school with other ld's medical requirements.	
Signed:			Date:		
	(Parent/Guardian)				
ection B		1	Medical Practitioner stamp here		
•	d by a medical practition(s) of the child requ				
l:					•••••
).					•••••
Medication to be	e administered during	g school hours:			
For Condition (1,2 etc)	Name of Medication	Dosage amount	Time to be administered	Additional information	
Signed:	(Medical Practitioner)		Da	te:	