St. Joseph's Primary School

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Marquet Street
MERRIWA NSW 2329
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PARENT PERMISSION – REGISTER OF ADMINISTRATION OF MEDICATION
(Schedule 2 & 3 Medications Casual Basis)

To be completed by Parent or Guardian

I, ____ request that
Parent/Guardian

my son / daughter ______________________________ of _____________
(name) (class)

be allowed to take medication at school under adult supervision according to my instructions listed below. 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 /Teacher of any changes involving the administration of the medication.

Signed ______________________________ Date ____________________
Parent/Guardian

Student Name:				
Commencement Date:		**Final Date:**		
Medication Name:	**Dosage:**	**Time of Administration**	**Special Instructions**	**Self Administer Yes/No**

REGISTER *(office use only)*

Date	Time	Dose	Student Signature	Staff Signature	Date	Time	Dose	Student Signature	Staff Signature

Empowering and challenging students to become lifelong learners