



Flemington Primary School

Mt Alexander Road (PO Box 7), Flemington 3031
Telephone: 9376 7137 / Facsimile: 9376 2230

CONSENT FOR MEDICATION

| | |
|-----------------------|---------------|
| NAME OF CHILD: | GRADE: |
|-----------------------|---------------|

Please provide details of medication, dosage, times, etc.

Medication: _____

Dosage: _____

Times: _____

Comments: _____

Please note that ALL medicines are to be clearly labelled with your child's name and required dosage of medication.

I consent to school staff supervising the administering of the above medicines to my child.

Signed:
(Parent / Guardian)

Date:

Office Use Only

Medication Administered

| Date | Time Administered | Administered by (name) | Signature |
|------|-------------------|------------------------|-----------|
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