WALES STREET PRIMARY SCHOOL
Wales Street, Thornbury VIC 3071
Ph: 03 9484 3949 Fax: 03 9480 5930

SHORT TERM PERMISSION – MEDICATION

CHILD'S NAME:		**YEAR:**	
MEDICATION:			
Reason for Administering: **Eg. Earache, tonsillitis**			
Dosage:			
Dates to be given:			
Times to be given:			

I give permission for a designated member of staff to administer the above medication to my child.

SIGNED:_____ Date:_____/____/____
Parent/Guardian

Health Centre use only

Date	Dosage	Time	Signature	Notes
		:		
		:		
		:		
		:		
		:		
		:		
		:		