ST AUGUSTINE'S COLLEGE
PERMISSION TO ADMINISTER MEDICATION

DETAILS OF MEDICATION TO BE ADMINISTERED BY THE COLLEGE

Student Name

Date of Birth

Homeroom

I hereby request that the College staff administer the following medication to my child at school or during camps, and excursions as specified below.

NOTE: All medications must be correctly labelled by a pharmacist.

NAME OF MEDICATION	DOSAGE	STRENGTH	INDICATIONS FOR USE
	(E.G. ONE TABLET)	(E.G. 10G)	(E.G. INSTRUCTIONS FOR WHEN AND HOW THIS MEDICATION IS TO BE USED
DURATION OF ADMINISTERED MEDICATION			

Additional information

Parent/Carer Name

Parent/Carer Signature

Phone Number

Date