# Medication permission form

Name of Student: _____ Date of Birth: _____

I, _____ hereby give permission for qualified staff at

Clayfield College to administer the following medication to my child.

| Name of medication | Prescribed by | Time | Dosage | Method of Administration |
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Time and date the medication was last administered: _____

Medical condition being treated: _____

Allergies: _____

- All medication is to be provided in the original packaging with dosage and times clearly visible.
- Any changes to the prescribed dosage must be made in writing to Clayfield College.

Signature: _____ Date: _____