



# Holy Trinity Inverell

*Live life to the full*

## MEDICAL PERMISSION FORM

Name of Student: \_\_\_\_\_

Date: \_\_\_\_\_ Class: \_\_\_\_\_

I \_\_\_\_\_ give permission for school staff  
(Parent / Guardian's name)

member/s to administer \_\_\_\_\_  
(Name of medication and quantity)

To the above named student at: \_\_\_\_\_ on \_\_\_\_\_  
(Time/s) (Day/Date)

Further information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signed: \_\_\_\_\_