Clayfield College

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.

Clayfield College to administer the following medication to my child.

Name of Medication	Prescribed By	Time	Dosage	Method of Administration

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: _____