GALILEE REGIONAL CATHOLIC PRIMARY SCHOOL

CONFIDENTIAL MEDICAL CONSENT

This medical form must be filled out and signed by the parent/guardian. PLEASE PRINT CAREFULLY. This form will be valid for 7 days only.

START DATE:	FINISH DATE:

Student's full name & date of birth and Grade.	Name	Grade	Date of Birth

Parent/Guardian name 1 & contact details	Contact Number:

Family doctor:	Name	Phone

Medication	Name of Medication: Dosage : Time/s to be given:

All medication must be given to the school office. All containers must be labelled with your child's name, the dosage as well as when and how it should be taken. The medications will be kept by the staff and distributed when required. the knowledge and approval of both the teacher-in-charge and yourself.

Parent/Guardian Signature of parent/guardian (named above):

Date:

DATE						
TIME/S						
GIVEN BY						
WITNESSED BY						