St Mary's Primary School Armidale

Request by Parent/Guardian for the Administration of Short Term Medication during School Hours

Name of Student: _____ **Class:**_____

Name of Medication: _____

Dose: _____

Time/s to be taken: _____

Special Arrangements (eg monitoring the student after administration, restrictions on participation in school activities such as sport or use of equipment, side effects, emergency actions.)

_____

Parent/Guardian Signature:_____

Please Print Name:_____ **Date:** _____