SOMERVILLE Primary School No. 2656

STUDENT MEDICATION PLAN. [CONFIDENTIAL]

PARENT/GUARDIAN CONSENT.

I give permission for the school to administer this medication. If my child's health condition deteriorates I give permission for the school to seek any medical attention that is deemed necessary by a medical practitioner.

ALL MEDICATION must be brought to school in its original package and labelled with your child's name, dose to be taken and when it should be taken. If it is necessary or appropriate for your child to carry their own medication [e.g. asthma puffers only] it must be with the knowledge and approval of both the teacher in charge and yourself.

STUDENT'S NAME:……GRADE:…….

PHONE: [H]……[W]…….[Mobile]……..

NAME OF FAMILY DOCTOR:……PH:.....

EMERGENCY CONTACT NO…….. NAME:……

STUDENT'S MEDICAL CONDITION:

……

……

NAME OF PARENT/GUARDIAN:……..

SIGNATURE:…… DATE:……..

Name of Medication/s	Dosage	Time to be Taken	How is it to be Taken? [e.g. orally/puffer]	Dates
				Start Date: / / **End Date:** / / □ **Ongoing medication**
				Start Date: / / **End Date:** / / □ **Ongoing Medication**
				Start Date: / / **End Date:** / / □ **Ongoing Medication**

STORAGE:
Does the medication require refrigeration? Yes/No

MEDICATION RECEIVED BY:…….SIGNATURE:…….