MEDICATION / TREATMENT ADVICE FORM

Canberra Grammar School
AN INDEPENDENT ANGLICAN SCHOOL

Name of Student _____ Date of Birth _____

I, _____ hereby give permission to qualified staff at CANBERRA GRAMMAR SCHOOL to administer the following medication to my child.

(Parent / Guardian Name)

Name of Medication	Prescribed by	Time	Dosage	Method of Administration

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 Canberra Grammar School.

Time and date the medication was last administered _____

Medical condition(s) of the child requiring treatment/medication _____

Allergies (please list) _____

Signed _____ Date _____

(Parent / Guardian Signature)

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FOR STAFF USE ONLY

Date	Medicine	Dosage	Time	Given by (name and signature)	Verified by (name and signature)