

# MEDICATION / TREATMENT ADVICE FORM

Canberra  
Grammar  
School



AN INDEPENDENT ANGLICAN SCHOOL

Name of Student

Date of Birth

I,

(Parent / Guardian Name)

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

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)

