



St Patrick's School
41 Yamala Street,
Emerald Qld 4720
Ph: 4982 2485
Fax: 4982 4229

**NOTIFICATION AND REQUEST FOR THE ADMINISTRATION OF
MEDICATION DURING SCHOOL HOURS**

To be completed by Parent / Guardian:

I request that my child:

(full name of child)

be allowed to take the following medication at school according to instructions from:

(full name of medication and prescribing Doctor)

The medication is to be taken at the following times and the dosage is:

(please list time/s and dosage of medication)

The medication has been prescribed for the following reason:

I hereby give permission to the Principal to obtain relevant information from the Prescribing Doctor.

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medication.

Signed:
(Parent / Guardian)

Date: / /