MARAYONG HEIGHTS PUBLIC SCHOOL Est. 1961

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PRESCRIBED MEDICATION TO BE ADMINISTERED DURING SCHOOL HOURS

Child's name:_____ Class: _____ D.O.B.:_____

Condition: _____

Name of medication: _____

Name of Medical Practitioner prescribing medication: _____

Phone No: _____

Required dosage: _____

Frequency or time of administration: _____

Before/after/with meals or Not Applicable: _____

Special instruction for administering medication: _____

_____

_____

Attached are the instructions of administration from my Medical Practitioner.

I hereby give permission for the staff of Marayong Heights Public School to administer the above medication indicated by the written instruction above.

Signature: _____ Date: _____
(Parent/Carer)

Marayong Heights Public School follows the guidelines from the NSW Department of Education and Training for prescribed medications.

Please note: All "over-the-counter" medications are classed as Prescribed Medications by the NSW Department of Education and Training therefore, the same guidelines apply as above.

Office Use Only

Medical Practitioner instructions attached ☐
ERN updated ☐
Medical Records updated ☐

Signature:_____ Date: _____