CONSENT FOR MEDICATION

Name of Student:	
Form Group:	

Name of Medication:		
Please specify how many to be given?		
When to be given:	**AM**	
	Lunch Break	
	PM	
or as required, ie. Pain Relief:	**YES / NO**	
Expiry Date:		

Please mark clearly your child's name on the medication pack.

Please send medication in the original packaging.

I/we authorise a First Aider to administer the above named medication and for the above item to be housed in the Medical Room.

Print Name (Parent/Carer):	
Relationship to Student:	
Signed By (Parent/Carer):	
Date:	

Please send the form to office@bwsgirls.org