

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 the Principal First Aider, Ms Yuliya Vasileva 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 for the attention of Ms Vasileva at
yvasileva@bwsgirls.org**