59-61 Stewart St, PO Box 859, Devonport, Tas 7310 T: (03) 64 241 744 F: (03) 64 231 795 W: www..olol.tas.edu.au ABN: 68 416 731 625

Appendix 2.3

Form 2: Short-term Prescribed Medication
To be completed by parent/guardian

Our Lady of Lourdes Catholic School

To: Carol Seagar *(Principal)*

I _____ Phone: _____
(Parent/Guardian)

request that medication be administered to my child during school hours

_____ Grade: _____
(Name of Student)

as prescribed by the child's medical practitioner.

☐ I have sent the medication to school in its original container with the pharmacist's labelled instructions attached.

The medication required is as follows:

Medication: _____
Dosage: _____
Method: _____
Time: _____
Directions: ☐ With Food ☐ Prior to Eating ☐ N/A

Yours sincerely

_____ _____
(Parent/Guardian's signature) *(Date)*

Office Use Only.....

Date	Medication	Time	Dose	Authorised Person's Signature	Student's Signature