



# St Francis De Sales, Catholic Primary School

626 Pascoe Vale Road Oak Park 3046

Tel: (03) 9306 9444 Email: principal@sfoakpark.catholic.edu.au

ABN: 87 246 330568



## Medication Permission Form

### Student Details

<b>Full name of Child</b>	
<b>Date of Birth</b>	
<b>Grade</b>	

### Parent Guardian Details

<b>Name of Parent   Guardian</b>	
<b>Address of Parent   Guardian</b>	
<b>Parent   Guardian Contact Number</b>	

### Contact Details – In the event of an Emergency

<b>First Contact Name</b>	
<b>First Contact Phone Number</b>	
<b>Second Contact Name</b>	
<b>Second Contact Phone Number</b>	

### Medical Practitioner Details

<b>Name of Family Doctor</b>	
<b>Doctor's Contact Number</b>	
<b>Address of Doctor:</b>	

### Medication Required

**Medication required must be properly labelled and in its original container and/or packaging**

<b>Name of Medication</b>	
<b>Dosage Amount</b>	
<b>Time/s to be taken</b>	
<b>How is it to be taken? (eg: Orally/topical/injection)</b>	
<b>Dates</b>	Start Date: End Date: Ongoing Medication:



Bloom where you are planted



# St Francis De Sales, Catholic Primary School

626 Pascoe Vale Road Oak Park 3046

Tel: (03) 9306 9444 Email: principal@sfoakpark.catholic.edu.au

ABN: 87 246 330568



## Request and Authorisation

No verbal permission is permitted and will be accepted

I, \_\_\_\_\_ (Name of Parent/Guardian)

Make the following request and authorisation for my child:

\_\_\_\_\_ in Grade \_\_\_\_\_

I hereby declare that it is not possible to make arrangements for the parent/guardian to administer required medication to my child and I therefore request and authorise the school administration of the following prescribed medication for my child

\_\_\_\_\_ in Grade \_\_\_\_\_

by non-medically trained staff at St Francis de Sales School, Oak Park.

Where I am unable to be contacted or it is otherwise impracticable for me to be contacted, I consent to my child receiving medical or surgical assistance as recommended by a medical practitioner in the event of any illness or accident; administer or consent to such first aid as the teacher in charge may consider to be reasonably necessary in the event of any illness or accident.

I accept all risks involved in the administration of medical, surgical or first aid treatment considered necessary and the responsibility for payment of all expenses incurred in relation to such treatment and any emergency transportation required.

I also acknowledge that if my child's medical history or needs have changed, I have provided all details to the First Aid Officers prior to the excursion taking place.

## Medical Conditions and/or Allergies

Please list any Medical Conditions we should be aware of:

\_\_\_\_\_  
\_\_\_\_\_

## Signature Panel MUST BE SIGNED for Permission to Administer Medication and Medical Consent

Parent/Guardian Name	
Parent/Guardian Contact Phone Number	
Signed	
Dated	

