ST AUGUSTINE'S COLLEGE - SYDNEY

FORM B

MEDICAL NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR STUDENT SELF ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS AND EXCURSIONS

Student's full name: _____

Medication details:

Condition	*Medication*	*Dosage*	*Time*	*Special instructions*

Recommended restrictions on participation in school activities? Yes ☐ No ☐

If yes, please give details: _____

_____

Any additional comments: _____

_____

_____

Doctor's name: _____

Doctor's address: _____

Doctor's phone number: _____

Doctor's signature: _____ Date: _____

I hereby give permission to St Augustine's College to obtain relevant information from the prescribing Doctor. I accept and agree to observe the conditions imposed by the College and understand and agree that it is my responsibility to inform the College of any changes involving the administration of medication.

Parent/Guardian name (please print):_____

Parent/Guardian signature: _____ Date: _____