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Parental/Guardian Agreement for the School to Administer non-prescribed medication or Supervise Self- Administration of medication.

The school will not authorise the administration of any medication unless a Parent/Guardian completes and signs this form.

Student Name _____ Form _____

Date of Birth _____

Medical condition _____

Medication to be taken _____

Dosage/instructions for administration/Storage _____

Duration medicine to be taken _____

Expiry date of Medication _____

I understand that I must deliver the medication personally to Reception/Welfare Room.

Parent/Guardian Signature _____

Date _____