CONSENT TO DISPENSE PRESCRIBED MEDICATION

I _____ request my son/daughter

_____ (name of student)

be given _____
(name of medication)

at _____ in dosages of _____
(times) *(ml or tablet)*

for _____
(name of medical condition)

In an emergency requiring medical attention I authorise the school to contact:

Doctor _____

Address _____

Telephone number _____

and/or to convey my child to the local hospital by appropriate transport which may be an ambulance.

Signed _____

Dated / /

INDIVIDUAL HEALTH CARE ACTION PLAN
FOR STUDENTS WITH A MEDICAL CONDITION

Name of student_____Class_____

Medical lllness_____

Usual medical treatment when child is well:

_____

_____

_____

He/she displays the following symptoms when unwell:

_____

_____

_____

Medication to be used/action to be taken when symptoms develop at school:

_____

_____

_____

In an emergency requiring medical attention, I authorise the school to contact:

Doctor:_____

Address:_____

Telephone number:_____

And/or to convey my child to the local hospital by appropriate transport which may be an ambulance.

Signature_____ Date_____