ST. AUGUSTINE'S CATHOLIC PRIMARY SCHOOL AND NURSERY

MEDICATION/ADMINISTRATION FORM

CHILD'S NAME……

CLASS……

NATURE OF ILLNESS……

……..

PRESCRIBED MEDICATION NECESSARY……...

……..

DOSAGE……

……..

TIMES ADVISED FOR ADMINISTRATION……...

……..

DOCTOR'S NAME, ADDRESS AND TEL.NO……

……..

……..

SIGNED……...

(PLEASE PRINT NAME)……

PARENT/GUARDIAN OF……

DATE…….