



Phone: (02) 4421 3630
Fax: (02) 4423 2861

*St Michael's School
North Street
PO Box 126
NOWRA NSW 2541*

Consent to Dispense Medicines Form

Appendix I

Student's Name: _____
(for whom medication has been prescribed)

I, _____ request my son/daughter
(parent/guardian)

to be given _____ at _____
(name of medication) (times)

in dosages of _____
(ml or tablets)

I can be contacted in an emergency at _____
(telephone number)

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

Doctor _____
(name of prescribing Doctor)

(address)

Telephone number _____

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

The medication has been / will be supplied in a container, clearly labelled with name of student requiring the medication, name of medication, appropriate dosage and time of administration.

Signature _____
(Parent/Guardian)

Privacy Note: *"This information is required to allow the school to achieve educational outcomes in the management of the health of your child. If the information is not provided, the school will not be able to dispense medications to your child. This form may be accessed at the school on request to the Principal."*



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Appendix 2 Medical Advice to School

To be completed by Prescribing Doctor in Serious/Special Circumstances

Student's Full Name: _____

School attending: _____

1. Medical condition(s) of the child requiring regular treatment:

MEDICATION DETAILS					
Condition Name	Medication Name	Dosage	Time/s of Admin	Special Instruction	Self-admin (Yes/No)

2. Essential medication requiring administration during school hours:

3. Recommended restrictions on participation in school activities (eg. sport, use of tools or machinery):

4. Recommended procedures in crisis situation

5. Additional comments:

Signed: _____ Date: _____
(Prescribing Doctor)



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