NORTHLAKES HIGH SCHOOL

Opportunities for Future Success

CONSENT TO DISPENSE MEDICATION
(to be completed by Parent/Guardian)

Student Name: _____ D.O.B. _____ Year: _____

Name of Medication: _____

Dosage & Time Required: _____

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Dosage & Time Required: _____

Any Special Requirements: _____

The school will make every endeavour to provide the medication at the times requested although some variations may be unavoidable on occasions. School staff will support your child's health care needs at school. This arrangement will be reviewed annually or when there is a change in your child's health needs or if the situation arises where this plan cannot be implemented.

The school has agreed that the prescribed medication will be delivered to the school by:

Parent/Guardian: _____Signature: _____

Contact Phone No: _____ Date: _____

Please provide the medication to the front office with the **child's name and dosage clearly marked**. We ask that parents/guardians contact the school if you are unable to provide medication as per arrangements.

If for any reason, there are any changes in your child's health care needs, you must inform the school as soon as possible. Please contact the school if at any time you have any concerns or questions about these arrangements for support. The school will work with you to support your child in managing the administering of this medication.

Yours sincerely

Mr W Welham
Principal