ST. THOMAS
DRYSDALE
OMNIA POSSIBILIA

ST THOMAS PRIMARY SCHOOL

MEDICATION CONSENT FORM

Students Name:- _____

Grade: _____

Teacher: _____

Illness/Condition: _____

_____

Name of Medication(s): _____

Dates/times to be given: _____

_____

Amount to be given: _____

Emergency Contacts: ***Parent/Guardian:*** _____

Phone: _____

Medical Practitioner's Name: _____

Medical Practitioner's Phone: _____

Ambulance Cover **Yes** ☐ **No** ☐

Ambulance Membership number: _____

I agree that an Ambulance may be called in case of a medical emergency.

I hereby give my permission that this medication to be administered to my child, as I have directed here. I Further consent that medical attention may be sought for my child, should it be deemed necessary.

Signature of Parent/Guardian: _____

Date: _____