TOOTGAROOK PRIMARY SCHOOL

ABN 962 081 501 89

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MEDICAL CONSENT FORM

Student Name _____

Year Level _____

Teacher _____

Name of Medication _____

Dates to be given _____

Times to be given _____
_____
_____

Amount to be given _____

Route of administration (only oral or inhalants apply) _____

Emergency Contacts – Parent/Guardian Ph: _____
- Medical Practitioner's Name: _____
- Medical Practitioner Ph: _____

I hereby give my consent that this medication 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: ____/____/ 2022