The Principal
Berowra Public School
BEROWRA 2081

I request that my child ……of class ……

be allowed to take …….. (dose) of ……

(name of medication) which has been prescribed by Dr ……..……

phone number …… for the treatment of ……

My child is to take dose/s at …… (time) each day commencing

…….…….. until ……..…….. (date of last dose).

☐ I will supply medication in a clearly labelled container, showing dosage to be taken.

☐ I have explained special storage requirements, if any, of medication eg refrigeration.

Requirement: ……

☐ I understand that I accept full responsibility for this action.

_____	_____	_____
Name	Signature	Date

In the presence of

_____	_____	_____
Witness Name	Signature	Date

Privacy notice
The information requested on this form is essential for assisting the school to plan for the support of your child's health needs. It will be used by the NSW department of Communities for the development of arrangements with you to support your child's health needs. Provision of this information is voluntary. If you do not provide all or any of this information, the school's capacity to support your child's health needs could be impaired. This information will be stored securely. You may correct any personal information provided at any time by contacting the Principal.