



OAKLEIGH PRIMARY SCHOOL and KINDERGARTEN

MEDICATION FORM

I authorise the teacher, or office staff in charge to administer the following medication to my child:

Student's Name: _____

Grade: _____

Medication: _____

Dosage: _____

Dates on which to administer medication: _____

Times at which to administer medication: _____

Signed: _____ (Parent/Guardian)

Date: ____/____/____