COOMERA ANGLICAN COLLEGE

ADMINISTRATION OF MEDICATION
Health Room

Student Name:	**Date of Birth:** / /
Allergies:	**Class:**
Condition:	
Prescribing Doctor:	

Please list all medications that your child requires during school hours.

Name of medication	Dosage	Time/s to be given at school	Date given	Time given	Given by

To be administered from: / / to / / (inclusive)

Parent/Carer (Print name):	
Signature:	**Date:**
Telephone number:	

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Anglican Church Southern Queensland