Haddon Primary School

Medication Plan

Name of student_____Class_____

Name of medication_____

Dosage_____

Special requirements (must be approved by students General Practitioner and school to have evidence of this.

_____

Parent consent:

I _____ consent to staff at Haddon Primary School to administer the above medication as directed to my child_____
I agree to abide by the schools policy (which I have received and read) for medication administration.
Signed_____Date_____

Date	Time	Administered by	Checked by