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THE TRUTH WILL SET US FREE

ABN 76 143 496 887

Short Term Permission- Medication Form

Childs Name:_____Class:_____

Name of Medication:_____

Reason for Administration:_____

Dosage:_____

Dates to be given:_____

Times to be given:_____

I give permission for a designated member of staff to administer the above medication to my child

Signed:_____Print Name:_____

Date:____/____/_____

Staff Use only

Date	Dosage	Time	Signature	Notes