Drury School

Respect Responsibility Kindness Excellence

CONSENT FOR MEDICINE TO BE GIVEN AT SCHOOL

Student Name:	Date:
Medicine:	
Dosage Amount:	Frequency:
Special Requirements (e.g. taken with/without food):	
Start Date:	Stop Date:
OR ☐ Medication to be kept at Drury School permanently (please tick)	

Declaration:

1. I give my consent and approve that nominated staff at Drury School administer the medication I have provided.

2. I accept that staff at the school will administer the above noted medication in accordance with the medical practitioner's directions on the package or bottle.

3. I understand that Drury School staff are not trained health professionals and will administer the medication to the best of their ability.

Parent/Caregiver Name:
Parent/Caregiver Signature: