



IONA PRESENTATION PRIMARY SCHOOL

FORM 3 Analgesics

Self Administration by Student of Analgesics/non prescribed medications for the relief of Temporary Conditions

I _____ (Parent/Carer of Student)

advise that I require my child (name) _____ (Class) _____ to self-administer

the following analgesic for the temporary condition of _____

Name of Medication _____

Dose child is to take _____

Time child is to take the medication _____

I understand that this medication will be stored in the administration office in a lockable cupboard and that my child will report to the Principal, Assistant Principal or Office Staff at the required time (as above)

Parent/Carer Signature Date _____

Principal's Signature Date _____