# BORONIA HEIGHTS PRIMARY SCHOOL

To Whom It May Concern:

My child, …………………………….…………. of Grade …………….. needs

to take ……………………………………………………(NAME OF MEDICINE).

They require ………………………………..… (DOSE)

To be given at ………………………………… (TIME)

I give permission for the medication to be administered by Boronia Heights Primary School staff.

SIGNED: ………………………………………….. DATE: ………………….
(Parent/Guardian)

To be filled in by office when medication given and returned to parent at end of week.

| DAY | DATE | DOSE | TIME | SIGNED |
|---|---|---|---|---|
| **Monday** | | | | |
| **Tuesday** | | | | |
| **Wednesday** | | | | |
| **Thursday** | | | | |
| **Friday** | | | | |