MEDICATION INDEMNITY FORM

THIS FORM NEEDS TO BE COMPLETED AND SIGNED BY YOU BEFORE WE ARE ALLOWED TO TREAT YOUR CHILD

CHILD'S SURNAME: ______________________________

CHILD'S FIRST NAME(S): ______________________________

DATE OF BIRTH: ______________________________

KNOWN ALLERGIES: ______________________________

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I, the undersigned, hereby grant permission for any basic medication, as approved by the school doctor, to be administered to my child by the Grantleigh San Sister.

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Signature of parent/guarding

____ (Please print clearly)
Full name and surname of parent/guardian

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Date