ST MARY OF THE CROSS MACKILLOP

47 FARMHOUSE BOULEVARD

EPPING NORTH

VICTORIA 3076

MEDICAL MANAGEMENT PLAN

CHILD'S NAME: ______________________________

DATE: ____________________

PARENT'S / CARER'S NAME: ____________________

TELEPHONE (Business Hours): _______________ **MOBILE:** __________________

Dear (Teacher's Name): ________________________

I request that my child be administered the following medication whilst at school:

NAME OF MEDICATION: ________________________

DOSAGE (Amount): ________________

TIME: ____________________

I have sent the medication in the original container displaying the instructions provided by the pharmacist and or medical practitioner.

Yours Sincerely,

____ **(Parent / Carer Signature)**