

MATER DEI COLLEGE
YEAR 12 RETREAT 2015
MEDICATION ADMINISTRATION REQUEST FORM (B)

I _____ the Parent/Guardian of _____ request that Mater Dei College supervises the administration of the following medication as prescribed by:

Dr _____ for the purpose of treating _____
(condition)

Name of Medication: _____

Dose: _____

Time/s to be taken: _____

Comments: _____

Parent/Guardian Signature: _____ **Date:** _____

I consent in the event of me not being contactable, for Mr Camuglia and/or Mater Dei College staff member to authorise emergency medical treatment on the advice of a qualified medical practitioner. I authorise College staff to administer first aid to my child in the event of an accident or minor ailment.

Parent/Guardian Signature: _____ **Date:** _____