HEBRON CHRISTIAN ACADEMY

CONSENT BY SCHOOL TO ADMINISTER MEDICATION

Parent/s: ……

As per your request dated ……/……/20……., the management of Hebron Christian Academy agree to administer the medicine as prescribed by the medical practitioner (attached) as follows:

- Learners full names: ……..
- Name/s of medication: a) ……..

  b) ……..

  c) ……..
- Dosage/s / quantity: …….
- At (time/s): ……..per day
- Period of prescription: ……...days

The medication will be administered for the period for which the (chronic or acute) medication is prescribed by the consulting medical practitioner, or until instructed otherwise in writing by the parent/s or medical practitioner

Names of teacher/school personnel member responsible:

Name: …… Signature: ……
(Senior Administrator)

Name: ……Signature: …….
(Principal)

Name: ……..…Signature: …….
(Class Teacher or First Aider)