INDIVIDUAL MEDICAL MANAGEMENT PLAN
PERMISSION TO ADMINISTER MEDICATION

I give permission for the teachers/staff at Little River Primary School to administer medication to my child and that the:-

- The medication is in its original package
- The Pharmacy label matches the information on this form
- Parent instructions given for appropriate storage and transport (if required)

Student’s Name .................................................................
Medication .................................................................
Dosage .................................................................
Start Date .............. .End Date .............. Ongoing ..............

Parents Signature ................................................................. Date ........................