



BURNSIDE HIGH SCHOOL

SICK-BAY MEDICATION REGISTER

This is to certify that this student is at present taking the following medication:

Student's Name:		
Form Class:		
Doctor & Telephone Number:		
Prescribed Medication:		
Over The Counter Medication:		

Instructions for Dispensing Medication			
Medication	Dose	Time	Reason for being on Medication

Authorisation for Dispensing Medication

- I, authorise a qualified person, designated by
(Caregiver's / Parent's Name)

the school, to administer the above medication to my son/daughter.

Caregiver's / Parent's Signature: Date:

- I, authorise a qualified person, designated by
(Student's Name)

the school, to administer the above medication to me.

Student's Signature: Date:

NB: *It is the student's responsibility to come to the Sick-Bay for medication. It is the parent's responsibility to advise the school of changes to medication.*

Office Use Only	
Number of tablets received:	Date:
Verified:	