



**M U L G R A V E**

**P R I M A R Y S C H O O L**

GLADESWOOD DRIVE,  
MULGRAVE 3170

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ABN: 65 484 530 572

My child, ..... of Grade ..... needs  
to take .....(NAME OF MEDICINE).

They require ..... (DOSE)

To be given at ..... (TIME)

I give permission for the medication to be administered by Mulgrave Primary School staff.

SIGNED: ..... DATE: .....  
(Parent/Guardian)

To be filled in by office when medication given.

<b>DAY</b>	<b>DATE</b>	<b>DOSE</b>	<b>TIME</b>	<b>SIGNED</b>
<b>Monday</b>				
<b>Tuesday</b>				
<b>Wednesday</b>				
<b>Thursday</b>				
<b>Friday</b>				