

**MOUNT WAVERLEY NORTH PRIMARY SCHOOL**

**OSHC MEDICATION CONSENT FORM**

**Child's Name:** .....

My child requires medication to be administered by staff whilst at OHSC.

**Name of Medication:** .....

**Reason for Medication:** .....

**Form of Medication:** Tablet: ..... Liquid: ..... Powder ..... Other .....

**Dosage:** .....

**Time/s to be Administered:** .....

**Method of Administration:** .....

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**Known Side Effects (if any):** .....

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**What action should be taken by OSHC Staff in the event of your child having a reaction to this medication?**

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**Correct Storage of Medication:** .....

**Commencement Date:** .....

**Completion Date:** .....

**Any Further Information:**

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**Name and Contact Telephone Number of Prescribing Physician:**

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**Parent/Guardian's Name:** .....

**Parent/Guardian's Signature:** ..... **Date:** .....