



Chisholm Catholic Primary School

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Form 2

Medical Advice to School

be completed by the prescribing doctor

Student's full name: _____

1. Medical condition(s) of the child requiring regular treatment:

2. Essential medication requiring administration during school hours:

Medication Details

Condition Name	Medication Name	Dosage	Time/s of administration	Special Instructions	Self administration (yes/no)

3. Recommended restrictions on participation in school activities (eg.sport)

4. Recommended procedure in crisis situation: _____

5. Additional comments: _____

Signature of prescribing doctor: _____ Date: _____