



Chisholm Catholic Primary School

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FORM 2

Date

Dear
Name of Prescribing Doctor

.....
Initial and Surname of Parent / Guardian

.....
Address of Parent / Guardian

has informed me that his / her child:
requires the administration of medication during school hours.

Please complete the details on the form attached to assist the school staff to ensure that the student named above receives the necessary attention.

You will note (see below) that the parent / guardian has given permission for the information to be released.

Yours faithfully,

Keiran Byrnes
Principal

Date

I
Parent / Guardian

hereby give permission for the release of information to Chisholm Catholic Primary School.

Signed: Date: