St Clare's Catholic High School

A Catholic school of excellence and improvement

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NOTIFICATION OF CHANGE TO MEDICATION

To be completed by parent/guardian

Name of student: _____

Name of prescribing doctor: _____

Reason for change: _____

_____

_____

Medication Details

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

Signature of parent/guardian: _____Date: _____