



St Clare's Catholic High School

A Catholic school of excellence and improvement

MEDICAL ADVICE TO SCHOOL

To be completed by 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 (e.g. sport, use of tools or machinery):

4. Recommended procedure in crisis situation:

5. Additional comments:

Signature of prescribing doctor: _____ Date: _____

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