



Corpus Christi Primary

GROWING TOGETHER AS THE BODY OF CHRIST

TEMPORARY MEDICATION PERMISSION SLIP

Please Note: all accessories (eg. Measuring cup) must be supplied.

Today's Date: _____

Students Name: _____ Class: _____

Date of Administration from: _____ to: _____

Time/s of Administration: _____

Medication Name: _____ Dosage: _____

Reason for Medication: _____

Does this medication need to be kept in refrigerator Yes / No

Parents/Guardian Name: _____ Signature _____



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