MEDICAL CERTIFICATE

INSTRUCTIONS FROM PEDIATRICIAN OR GENERAL PRACTIONER TO ADMINISTER MEDICATION AT SCHOOL

This is to certify that during school time the following student:

Surname:______________________

Name: _________________________

Date of birth: ___________________

Home address:____________________________________Town:__________________________

Name of School: __________________________________ Class:___________________________

Suffering from:____

In case of an emergency due to:____

which can be shown by the following symptoms: ____

NEEDS TO BE GIVEN THE FOLLOWING MEDICATION BY UNQUALIFIED FIRST AIDERS:

Medication trade name: ____

Mode of administration: ____

Dosage: ____

Mode of storage: ____

Notes:

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This is also to certify that that the administration of medicines can be carried out by unqualified individuals who have been appropriately informed/instructed.

Date: ______________________

STAMP AND SIGNATURE