

PARENT/GUARDIAN REQUEST FOR PARNELL DISTRICT SCHOOL TO ADMINISTER MEDICATION

1. I / we request that (student's name) Roomof
..... (address) be given medication at Parnell District School.
2. I / we accept that the school does not have a trained medical officer to administer medications.
3. I / we accept responsibility for the decision to give this medication to my / our child and acknowledge the school is in no way responsible for that decision.
4. I / we also accept that the school cannot guarantee that the medication will be given at a precise time or by the same person, although every endeavour will be made to do so.
5. I / we will notify the school about any changes to dose and frequency and recommended time when medication is to be given and fill out a new request form
6. I / we understand that full consultation may be necessary between ourselves, a medical practitioner and the principal when the medicine is either a restricted or controlled drug within the meaning of the Medicines Act 1983. A medical certificate may be required before administration.
7. I/We understand the 1st dose of any medication to be received by the student must not be administered by the school.

Name of Medication:

Reason for Medication:(optional)

Dosage and time to be given at school:

Expiry Date of Medication: (on container)

Date Medication to Cease:

Special Storage Requirements:

Known Side Effects i.e. allergies:

Name and Phone No of GP or Specialist:

Parents or Guardians Phone number during school hours:

After Hours: Emergency Contact Number:

Relationship to Child:

Signed: