Request to Administer Medicine at School

I/we request that ____ (student's name)

of (address) ____ Date of Birth _____________

be given medication (as stated below) at school.

1. 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.
2. I/we accept that the school cannot guarantee that the medication shall be given at a precise time or by the school nurse, although every endeavour shall be made to do so.
3. I/we will notify the school nurse about any changes to doses and recommended time when medication is to be given, and fill out a new request form.
4. I/we recognise that the medication is given at my/our request and that any future effects on my/our child is not now, or at any time in the future, the school's responsibility.
5. I/we recognise that the responsibility to provide the school with a supply of medication is my/ours.

Health Issue: ____

Name of Medication: ____

Dosage: ____

Time of Administration: ____

Expiry date of medication (on container): ____

When medication is to finish: ____

Any side effects of medication: ____

Name and phone number of Doctor/Specialist: ____

Pharmacy: ____

Parent/Caregivers phone number during school hours: _____________________________________

Emergency name and contact number: ____

Full name of Parent/Caregiver: ____

Relationship to student: ____

Signed (Parent/Caregiver): _______________________________________ Date: __________________

Signature of School Nurse: _______________________________________ Date: __________________