



Request to Administer Medicine at School

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

of (address) _____

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 mine/ours.

Health Issue: _____

Name of Medication: _____

Dosage: _____

Time of Administration: _____

Expiry date of medication (on container) _____

Date 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: _____