

Administration of Medicines at School

Child's Name _____ Room _____

Date of Birth _____ Parent/Caregiver Name _____

Daytime Contact Number _____ or _____

My child requires the following prescription medication at school;

It needs to be taken at _____ (time) or when needs dictate (please circle)

Start Date _____ Finish
Date _____

My child will administer his/her own medication YES / NO

My child needs supervision with taking his/her medication YES / NO

My child requires an adult to give the medication YES / NO

My child is taking this medication because h/she has;

I accept full responsibility for maintaining supplies, having my child's name, the name of the drug and the correct dose on the container, and that the supplies will not have passed the expiry date. I have given permission for a member of the school staff to administer the medication according to my child's needs as indicated above and accept that this may not be the same staff member each time. I accept that the school will take due care with the administration of this medication but I release the school and the school's staff from any responsibility associated with it. Like wise I understand that the school cannot be held responsible for any injury or fatality if correct procedures and systems have been followed.

Full Name _____

Signature _____ Date _____

Phone _____ Emergency Phone _____

Approved by Principal:

Signed _____ Date _____