Ellerslie School
EST 1877

ADMINISTRATION OF MEDICINES AT SCHOOL

Child's Name: _____ Room No: _____

Date of Birth: _____

Parent/Caregiver Name: _____

Daytime Contact Number: _____ or _____

My child requires the following prescription medication at school:

_____

_____

_____

Reason for Medication: _____

_____

It needs to be taken at: _____ (time)

Start Date: _____ Finish Date: _____

- My child will administer his/her own medication: Yes / No
- If yes please give details: _____

_____

- My child needs supervision with taking his/her medication: Yes / No
- My child requires an adult to give the medication: Yes / No

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 give 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.

I accept that it is my child's responsibility to come to the office for their medication at the appropriate time.

I will inform the school in writing if there is any change in the above medication information. The school will accept responsibility for keeping this information in a safe place.

Full Name: _____

Signature: _____

Date: _____

Approved by Principal:

Signature: _____

Date: _____