PROCEDURE DOC 10

Parent/Guardians Request for Holy Cross School to administer medication.

I/we request that; (child's name) _____ of

(address) _____ be given

medication at _____name of school

1. I/we accept that the school does not have a trained medical officer to administer medications.

2. 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.

3. 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 endeavor will be made to do so.

4. I/we will notify the school about any changes to dose and recommended time when medication is to be given and fill out a new request form.

Name of medication: _____

Dosage and time to be given at school: _____

Expiry date of medication (on container): _____

Date when medication is to finish: _____

Special storage requirements, i.e., in fridge etc: _____

Any side effects of medication: _____

Name & phone no. of GP or specialist (if applicable): _____

Parent or guardians phone no. during school hours: _____

after hours: _____

Emergency contact number: _____

Signed: Full Name: _____

Relationship to child: _____ Date: _____