SACRED HEART SCHOOL BOGGABRI

Long Term Administration of Medication at School

Appendix 13

NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

This is a reminder that the School's Administration of Medication Policy and Anaphylaxis Policy requires the following information to be completed by the Parent/Guardian

I request that my child:

_____

Full Name of Student

be allowed to take medication at school according to instructions from:

_____

Full name of Prescribing Doctor

_____

_____

Address & Phone number of Prescribing Doctor

The medication has been prescribed for the following reason:

_____

_____

I hereby give permission to the Principal to obtain relevant information from the Prescribing Doctor.

Name of Medication: _____
(all medication must be in original packaging)

Dosage to be given: _____

Time(s) to be given: _____

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medication.

Signed: _____ Date: _____
Parent/Guardian