## REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Date: _____

I/We request that *(child's name)*: _____ Room _____

of *(address)*: _____

be administered medication at St Michael's Catholic 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 and/or its agent cannot be held responsible for any subsequent side effects of any medication administered by an agent of the school or as a result of the physical administration of the medication.

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 endeavour will be made to do so.

4. I/We will notify the school about any changes to dosage or modified time when medication is to be given.

5. I/We accept that the school will take all reasonable care with the storage and security of the medication, but is in no way liable for damage or loss.

Specific Medication: _____

Purpose of Medication: _____

Dosage and Time of Administration: _____

Expiry Date: _____

Storage Requirements: _____

Any Known Side Effects: _____

Name of G.P: _____ Phone No: _____

Emergency Contacts: _____ Phone No: _____

_____ Phone No: _____

Parent/Caregiver's Name: _____ Signature: _____

_____ Signature: _____