REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Date:

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

be administered medication at Kaurilands 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: