



## **REQUEST FOR SCHOOL TO ADMINISTER MEDICATION**

**Your child's Name:**

**Room No:**

**Date:**

I/We request that the above named child 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 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.

Parent/Caregiver's Name:

Signature: