

**ST MARY'S CATHOLIC SCHOOL**

**PARENT / CAREGIVER REQUEST FOR ADMINISTERING MEDICATION**

**Child's Name:** ..... **Room No:** .....

**Address:** .....

**Doctor / Medical Centre:** ..... **Telephone:** .....  
 (These details are required to verify that medication needs to be taken during school hours)

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

In requesting this service, I / We undertake not to hold the school and staff responsible for any future effects on my / our child as a result of administering the medication as specified.

I / We request the school secretary / office staff member to assume responsibility for the administration of medication as detailed below to the named child.

I / We have provided the medication in its original container, which includes the child's name, pharmacist's label, dosage and directions.

I / We accept responsibility to:  maintain the supply  
 collect any left over medication at the date of final dosage as indicated below

I / We accept that the school cannot guarantee that the medication will be given at a precise time (or by the same person), although I / We understand that every endeavour will be made to do so.

I / We will notify the school about any changes to dose or when medication time is to be adjusted. Signed adjustments will be made to the original request form for the same medication or a new form will be completed for new medication.

Name of Medication: .....

Dosage and time to be given at school: .....

Other requirement: (i.e. with / before / after food etc) .....

Date when medication is to finish: .....

Special storage requirements: (i.e. fridge) .....

Any known side effects: .....

Parent / Caregiver's Current Contact Telephone No: .....

.....  
 (Parent / Caregiver's Signature)

.....  
 (Dated)

**SCHOOL STAFF TO ADMINISTER MEDICATION**

(to be completed by staff)

1. Name: ..... Signature: .....

2. Name: ..... Signature: .....

3. Name: ..... Signature: .....