ADMINISTRATION OF MEDICATION

NAME OF CHILD: ................................................................. YEAR LEVEL: ........................................

For any type of medication that your child needs to take during school hours, please provide the following information:

PARENTAL PERMISSION TO ADMINISTER MEDICATION

I (parent/guardian) ............................................................. give permission for medication to be administered to my son/daughter (child’s name) ..............................................................

DETAILS OF MEDICATION

NAME OF MEDICATION
.............................................................................................................................

REASON FOR MEDICATION
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DOSEAGE
Date/s: ................................................................. Time/s: .................................................................
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Parent/Guardian Signature: .................................................................................................................................

PLEASE NOTE

1) Medication should be in its original packaging.
2) Medication should be clearly labelled.
3) Children should never be responsible for their own medication.
4) All medications will be kept in a secure cupboard.
5) All medication should be forwarded to your child’s classroom teacher accompanied by a notice.
6) Children, especially in the older classes, need to take some responsibility for remembering to take medication.