

FORM: Medication Administration Request

If placed on school letter head all requirements must be retained.

Student's Full Name:	Class:	Year: 2024
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This form must be completed for medication to be administered to your child during school hours. It has been designed to ensure the safety of your child and to protect school staff who do not have medical training.

All medications must be prescribed by a medical practitioner must be labelled with a pharmacy label and may also require further written medical advice.

Over the counter medication or alternative or supplementary medicines, must have this form completed by the parent / legal guardian, the medication be in the original container with dosage instructions and labelled with the student's name and grade level.

It is upon Principal discretion if the School will require further requirements to administer Over the Counter medication, and may require a pharmacy label affixed to the original container, and / or medical written advice from the students medical practitioner.

Section 1 is to be completed by you *or* your child's medical practitioner.

Section 2 is to be completed by you. Please return the completed form to the school.

Section 1 Medication instructions as prescribed by a medical practitioner

These instructions are as **prescribed by the student's medical practitioner (prescribed medication)**, or **prescribed by the parent / legal guardian (non-prescribed medication)** to enable the school to maintain its *duty of care* when administering medication to students whose condition would otherwise preclude attendance at school.

Type of Medication:	<input type="checkbox"/> Prescription Medication	<input type="checkbox"/> Over the counter (non-prescribed)
Instructions from a Medical Practitioner provided via:	<input type="checkbox"/> Pharmacy label <input type="checkbox"/> Written medical advice <i>(at least one must be provided)</i>	
Medical Practitioner's Name:		
Address:		
Name of Student:		
Name of Medication:		
Dose:		
Time to be taken:		
Commencement date:		
Conclusion date:		

Special arrangements: (e.g. monitoring the student after administration; restrictions on participation in school activities such as sports or use of machinery; side effects; emergency actions.)

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Section 2

Notification and request by parent or person with legal responsibility for student for the administration of medication during school hours

I request administration of medication as instructed above for my child. I understand the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may arise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

Full name of student:			
Date of birth:		Grade:	
Parent/legal guardian Name:			
Parent/legal guardian Signature:		Date:	