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**Application for School to administer medication**

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| **DETAILS OF STUDENT:**  Name:………………………………………………………………… Class:………………………………………  Date of Birth:……………………………………………………………………………………………………………………  Reason for medication:…………………………………………………………………………………………………….... |
| **MEDICATION:**  Name/Type of Medication **(as described on the container):………………………………………………………..**  Date dispensed:……………………………………………………………………………………………………………….  Storage requirements:………………………………………………………………………………………………………..  Expiry Date:……………………………………………………………………………………………………………………..  **NB: Medicines must be in the original container as dispensed by the pharmacy.** |
| **FULL DIRECTIONS FOR USE:**  Dosage and amount **(as per instructions on container)**;  Method:………………………………………………………………………………………………………………………….  Timing/Frequency of dosage:……………………………………………………………………………………………….  Dates to administer: From …………………………………..…..…. To ……………………………….………….  **(Maximum of 5 days unless prescribed by a GP)**  Special precautions – are here any side effects that the school should know about?  ……………………………………………………………………………………………………………………………………… |
| Is your child attending wrap around care while taking this medication: Yes / No **(delete as appropriate)** |
| I confirm that the above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. I understand that I must deliver the medication personally to the school office and that the school will not be held responsible for any adverse effects from the medication.  Signature:…………………………………………………Relationship to student:………………………………………  Date:……………………………………………………………………………………………………………………………… |