BUCKLAND SCHOOL

Parent / Guardian request for Buckland School to Administer Medication

I / we request that (Child's name) _____

Of (address) _____
Be given medication at Buckland School.

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

2. 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.

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 doses – and recommended time when medication is to be given, and fill out a new request from.

Name of medication: _____

Dosage to be given at school _____

Time to be given: _____

Expiry date of medication: _____

Date when medication commenced: _____

Date when medication is to finish: _____

Special storage requirements – i.e. fridge etc: _____

Any side effects of medication: _____

Name and phone number of GP or specialist (if applicable) _____

_____

Parent / Guardian phone numbers during school hours: _____

Emergency Contact Number:_____

Signed: Full Name: _____

Relationship to Child:_____ Date: _____