**REQUEST TO ADMINISTER MEDICATION AT SCHOOL**

**SCHOOL NAME: ………………………………………………………..**

**STUDENT NAME: ……………………………………………….GENDER: ………..**

**DATE OF BIRTH / / YEAR LEVEL: ……………………………………………..**

**To be completed by Parent / Guardian with the Medical Practitioner and returned to the SCHOOL**

Please list all the medications that the student requires during school hours and any emergency medications.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Medication** | **Strength (e.g. 5 mg)** | **Dosage (e.g. 1 tablet)** | **Route of Administration (e.g. Oral, via nose)** | **Time to be given at school** | **Other important instructions (e.g. storage instructions or student self-administers medication)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

I request that school staff administer the necessary medication to this student while at school. I confirm the above information provides the school with the complete and necessary information to administer the medication. I also understand and agree that it is my responsibility (parent / guardian) to inform the Principal of any changes involving the administration of the medication and will do so in writing as specified in the schools Medication Policy.

Parent / Guardian – PRINT NAME: ………………………………………………………………..

Signature: …………………………………Phone: . …………………….Date: ………………….

Authorising Medical Practitioner – PRINT NAME…………………………………………………..

Apply practice stamp:

Signature: …………………………………Phone: ……………………….Date: ……………..

This authorisation applies for the period Term \* to Term \* Year:……………

**NOTE:** For **school staff** to administer any medication including ‘*over the counter medication’*, **authorisation is required from a medical practitioner.**

*Office Only: When this course of medication concludes, please retain this form in the student’s school file.*