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)

Catholic Schools Broken Bay
Caroline Chisholm Centre Building 2, 423 Pennant Hills Road, Pennant Hills, NSW 2120 | PO BOX 967 Pennant Hills NSW 1715
02 9847 0000 | csodbb.catholic.edu.au | cso@dbb.catholic.edu.au

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.