Cambewarra Public School

REQUEST FOR ADMINISTERING PRESCRIBED MEDICINES

Attention: Principal: Susan Hilliar

I hereby request that School Staff assist in the administering of prescribed medication to my child ___________________________ of Class _______ during school hours.

Details are provided:

Medication(s): ________________________________________________________

Reason: ________________________________________________________

Dosage: ______________________________________________________________

Time: _____________________________________

Directions: _____________________________________________________

Additional information:

I understand that one only day's dosage should be sent daily. I will advise the school of any changes to the above information.

SHORT TERM: The following conditions relate to students receiving short term medication, i.e on a day to day basis for a short term condition:

1) I understand that it is the responsibility of my child to attend the staff member or office to receive this dose.
2) I also understand that the medication will need to be collected from the staff member/office at the end of the school day.

LONG TERM: The following conditions relate to students receiving medication on a long term basis, i.e those students with a diagnosed chronic condition receiving daily medication:

1) I understand that it is the responsibility of my child to attend the staff member/office to receive this dose.
2) I also understand that it is my responsibility to provide the school with the necessary medication and to ensure adequate stocks are on hand at all times.

In consideration of the staff at Cambewarra Public School, I hereby indemnify all staff against all actions, suits, claims, demands, proceedings, losses, damages, compensation, costs, charges and any expenses whatsoever in respect of any personal injury or of any infringement, disturbance or destruction of any rights of any person including myself and my son/daughter/ward ___________________________ arising directly or indirectly out of the aforementioned administration of medication.

NAME OF PARENT/GUARDIAN/CAREGIVER:

_________________________________ SIGNED: _____________________ DATE: ___