NOWER HILL HIGH SCHOOL

REQUEST FOR SCHOOL TO ADMINISTER PRESCRIBED/OVER THE COUNTER MEDICATION AS AGREED BY THE SCHOOL NURSE

(the School will not give your child any medication unless you complete and sign this form with agreement of the School Nurse)

STUDENT'S NAME……..FORM: ……..

ADDRESS: ……

……DATE OF BIRTH:……

CONDITION OR ILLNESS:……...

NAME OF MEDICATION: ……..

HOW LONG WILL CHILD REQUIRE MEDICATION:……

DATE MEDICATION DISPENSED:……...

DOSAGE AND METHOD: i.e. 5mg tablet by mouth etc……..

TIMING i.e.4 hourly/once a day ……..

ANY POSSIBLE SIDE EFFECTS i.e.skin rash/vomiting:……..

SIGNATURE OF SCHOOL NURSE:……..

***PARENT/CARER CONTACT DETAILS**:……...*

NAME:……

DAYTIME TELEPHONE No:……...

RELATIONSHIP TO STUDENT:……...

I understand that I must deliver the medicine to the School Nurse (if I wish the School to administer medication or supply my child as necessary) and accept that this is a service which the School is not obliged to undertake. I understand that it is my responsibility to dispose of the medication when no longer needed.

Date: ……... Signature ……

ALL MEDICATION MUST BE CLEARLY LABELLED WITHIN ITS ORIGINAL CONTAINER WITH EXPIRY DATE CLEARLY VISIBLE. A DOCTOR'S LETTER OR PRESCRIPTION COPY MAY BE REQUIRED.