ADMINISTRATION OF Medicines at School

Child's Name _____ Room _____

Date of Birth _____ Parents Name _____

Daytime Contact Number _____

My child requires the following prescription medication at school :

_____

It needs to be taken at _____(time) or when needs dictate (please circle)

My children will administer his/her own medication YES/NO

My child needs supervision with taking this medications YES/NO

My child requires an adult to give this medication YES/NO

My child is taking this medication because he/she has

_____

_____

_____

I ACCEPT FULL RESPONSIBILITY FOR MAINTAINING SUPPLIES, HAVING MY CHILD'S NAME, THE NAME OF THE DRUG AND THE CORRECT DOSE ON THE CONTAINER, AND THAT THE SUPPLIES WILL NOT HAVE PASSED THE EXPIRY DATE. I HAVE GIVEN PERMISSION FOR A MEMBER OF THE SCHOOL STAFF TO ADMINISTER THE MEDICATION ACCORDING TO MY CHILD'S NEEDS AS INDICATED ABOVE AND ACCPET THAT THIS MAY NOT BE THE SAME STAFF MEMBER EACH TIME. I ACCEPT THAT THE SCHOOL WILL TAKE DUE CARE WITH THE ADMINIISTRATON OF THIS MEDICATION BUT I RELEASE THE SCHOOL AND THE SCHOOL'S STAFF FROM ANY RESPONSIBILITY ASSOCIATED WITH IT. LIKE WISE I UNDERSTAND THAT THE SCHOOL CANNOT BE HELD RESPONSIBLE FOR ANY INJURY OR FATALITY IF CORRECT PROCEDURES AND SYSTEMS HAVE BEEN FOLLOWED.

PARENTS FULL NAME_____

SIGNATURE_____

PHONE IF DFFERENT FROM ABOVE_____

DATE_____

Approved by_____

Signature _____ Date _____