# Administration of Medicines at Ōpaheke School

Child's Name: _____ Room: _____

Date of Birth: _____

My child requires the following medication at school:

_____

It needs to be taken _____

Start Date: _____ Finish Date: _____

**Please circle the applicable statement:**

- My child will administer his/her own medication
- My child needs supervision with taking his/her medication
- My child requires an adult to give the medication

My child is taking this medication because he/she has:

_____

_____

By signing below, I accept full responsibility for maintaining supplies, having my child's name, the name of the medication 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 accept that this may not be the same staff member each time. I accept that the school will take due care with the administration of this medication, but I release the school and the school's staff from any responsibility associate with it. Likewise, I understand that the school cannot be held responsible for any injury or fatality if correct procedures and systems have been followed.

Parent/Caregiver Name: _____

Signature: _____ Date: _____

Emergency phone number: _____