St Angela's Primary School

40 Harrington Ave Castle Hill NSW 2154
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(School Form 2018MED-STB) During School Hours – Short Term Basis Only (1-5 days)
Request for Administration of PRESCRIBED Medication
TO BE COMPLETED BY PARENT

Date: _____

Student's Name: _____ Class: _____

Period of Treatment: From: ___/___/___ to: ___/___/___

Prescribing Doctor: _____

Medical Condition requiring Medication: _____

Name of Medication: _____

Dosage: _____

Time to be Administered: _____

Special Instructions (if any): _____

Conditions: ***Prescribed*** **medication will only be given to children with the written permission of parents. Medication for your child must be supplied in its original container, clearly labelled with your child's name, the name of the medication, dosage and frequency of administration. Appropriate equipment for administration is to be supplied by the parent. Medication is required to be delivered to and collected from the school office by a parent. For safety reasons, medication is not permitted to be carried by children.**

I/We accept and agree to observe the conditions (as stated above) by the school and understand and agree that it is my/our responsibility to inform the school of any changes involving the administration of the medication.

Parent/Guardian Name: _____
(please print)

Parent/Guardian Signature: _____

Daytime Contact No: _____

Parent Request for Administration of PRESCRIBED Medication During School Hours - Short Term Basis Only (1-5 days)

Medication Register

Date	Time	Name of Student	Class	Name of Medication	Dosage	Supervisors' Signatures (2 people)