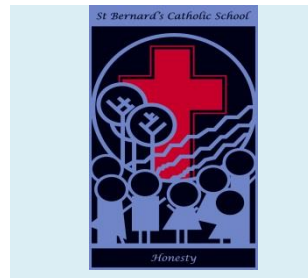


NOTIFICATION AND REQUEST BY PARENT / GUARDIAN FOR THE ADMINISTRATION OF MEDICATION



Name of School:

To be completed by Parent / Carer and returned to the principal.

I request that my child - Name:Class.....

Date of Birth:Gender:

be given medication in accordance with the following instructions for the period –
Term & date.....to Term and date.....

NAME OF MEDICATION:

DOSAGE & FREQUENCY:

ADMINISTRATION: By Self Requires assistance

Other comments / special instructions:

Storage instructions: Fridge: Other: (specify).....

Authority by Doctor:

I confirm the above information provides the school with the complete and necessary
information to administer medication to (name of child).....

TREATING DOCTORS NAME (please print):

ADDRESS (Please print):

Doctor's SIGNATURE and practice stamp:

I confirm the above information provides the school with the complete and necessary
information to administer this medication to

I also understand and agree that it is my responsibility (parent / carer) to inform the
Principal of any changes involving the administration of the medication.

Parent / Carer Signature:Date:

In the event of emergency, contact:

(1) Name of Parent / Carer.....Phone:

(2) Name.....Phone:.....

*When this course of medication concludes, please retain this form in the student's
school file.*