Chisholm Catholic Primary School

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FORM 1

Date ……..

Re Notification and request for the administration of medication during school hours

I request the school to administer prescribed medication at school, during school hours to my son / daughter ..... according to the following medication details. All medication is to be presented to the student foyer in original packaging for dispensing.

Student's name: .....

Prescribing Doctor: .....

Address & phone number of prescribing Doctor: .....

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Medical condition requiring medication: .....

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Period of treatment: .....

Type of medication: .....

Dosage: .....

Times of administration: .....

Special instructions: .....

I / We accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medicine.

I / We agree to indemnify the School and related parties on the terms of the attached Deed of Indemnity.

Yours faithfully,

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Parent / Guardian