2021 REQUEST TO ADMINISTER MEDICATION

Medication cannot be administered to any child until this form is completed in full and signed by a responsible person. Please hand to the Class Teacher with prescribed medication.

Child's Full Name: _____ Grade: _____

Reason for Medication: ☐ Medical Condition ☐ Allergy Relief ☐ Pain Relief ☐ Other

Name of Medication: _____ Dosage: _____

Time/s at which medication is to be administered:

☐ Play time 11.00am ☐ Lunch time 12.20pm ☐ Other Times/s _____

Start Date: ____/____/2021 End Date: ☐ 17/12/2021 ☐ Other _____/_____/2021

Where is medication to be kept at school? ☐ First Aid Medicine Cupboard

☐ First Aid Fridge ☐ Out of School Hours Care ☐ Other_____

Medication to be administered by:

☐ _____ ☐ First Aid Officer /PCS Staff Member ☐ OSHC Staff

Please provide any other information that Staff should be aware of? _____

_____

_____

_____

_____

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_____

I have supplied the above medication & request that my child be administered this medication in accordance with the directions on the pharmacy label or manufacturer's instructions and in accordance with instructions specified on an Asthma or Anaphylaxis or Allergy Action Plan or treating Medical Health Care Professional's written instructions provided on their Medical Clinic's letterhead, which is reflected, as I have detailed above.

Signed: _____ Date: _____/ _____/2021
(Parent/Carer)

☐ *Please provide PCS Out of School Hours Care (OSHC) with a copy of this AAP.*

☐ *Please send supplied medication home at the end of the school day*

OFFICE USE ONLY	Information/Brief provided to:				
	☐ Classroom teacher	☐ Specialist Teacher	☐ OSHC	☐ Entered CASES	☐ Medicine File Created