Administration of Medicine

The school should only be "requested" to administer medication during the school day, when it is impossible for the parent/guardian to do.

Student's full Name:			
Family's address:			
Phone number (land)		**Phone number (mobile)**	
Doctor:		**Phone:**	
Doctor's Address:			

1. Please tick if your child has any of the following conditions:

	Migraine		Epilepsy		Asthma		Diabetes
	Travel sickness		Fits of any type		Heart condition		Dizzy spells
	Colour blindness		Chronic nose bleeds				
	Other: (please specify)						

2. MEDICATION

	What condition is the medication for?
	What is the name of the medication?
	How much does your child need to take and when is it taken?
	Please write down how much medication you are giving the school? Eg 30 tablets
	Is there any other treatment your child is having?

3. Is your child allergic to any of the following?

	Prescription medicine	Yes / No	Details:
	Food	Yes / No	Details:
	Insect bites or stings	Yes / No	Details:
	Other allergies?	Yes / No	Details:

Emergency Contact Details

Emergency contact: Name:		
Address:		
Day phone:	Evening phone:	Cell phone:
Relationship to child:		

- I agree to let the school know about any changes to this information.
- I understand that if my child has prescription medicine to take, I will supply it fully labelled, closed securely, and with full instructions. It will be given to a designated adult who will administer the medicine.

Name:	
Signature:	Date: / /

RECORD OF MEDICATION GIVEN AT SCHOOL

STUDENT NAME:		
NAME OF MEDICATION HANDED IN AT SCHOOL:		
DATE HANDED IN:		
HOW MUCH MEDICATION HANDED IN? - EG 30 Tablets.		
DATE	**HOW MUCH GIVEN? -eg 1 tablet**	**SIGNED- Name of teacher/teacher aide**

Please keep this at school after completed!