CRANBOURNE PRIMARY SCHOOL

PUPIL MEDICATION FORM

PARENTAL AUTHORISATION

I give permission for my child to be given the medication, during school time, as outlined on this form.

I understand that a responsible person will administer the medication .

I accept that it is my responsibility to:

a. Complete all details on this form.
b. Notify the office of any changes to the dosage as outlined.
c. Provide, in writing the name of the medication, dosage and frequency.
d. Provide a suitable container with the pupil's name and medication details clearly written on a label.
e. Inform the office when the medication is no longer needed.
f. Ensure that one week's supply of the medication is held at school; it is my responsibility to provide a medicine cup where required or the correct dosage for each day eg. ½ tablet.
g. Ensure that further replacements of the medication are safely delivered to the office (children cannot be given this responsibility).

I also give permission for the teacher in charge to seek medical assistance for my child if he/she has an adverse reaction to the medicine and I cannot be contacted immediately.

DETAILS OF MEDICATION TO BE ADMINISTERED AT SCHOOL

NAME OF PUPIL: ________________________________ **GRADE:** _______________

NAME OF MEDICATION ______________________________

DOSAGE ______________________________

FREQUENCY ______________________________

DURATION OF COURSE OF TREATMENT ________________

REFRIGERATION IS REQUIRED **YES** ☐ **NO** ☐

SIGNED :_____________________________________ **DATE**: _______________

TELEPHONE NO: _________________________