TOKOMARU SCHOOL ADMINSTERING ORAL MEDICATION FORM

I/we request that _____ (student's name) of Room _____ be given medication at Tokomaru School.

1. I/we accept that the school does not have a trained medical officer to administer medications.
2. I/we accept responsibility for the decision to give this medication to my/our child, and acknowledge the school is in no way responsible for that decision.
3. I/we accept that the school cannot guarantee that the medication will be given at a precise time or by the same person, although every endeavour will be made to do so.
4. I/we will notify the school of any changes to dosage or recommended time when mediation is to be given.

Name of Medication: _____

Dosage and time to be given at school: _____

Date when medication is to finish: _____

Special storage requirements, ie in fridge etc: _____

Any side effects of medication: _____

Name & Phone number of Doctor or Specialist: _____
(if applicable)

Signed: _____ (parent/caregiver) Date: _____

RECORD OF ADMINISTRATION

Date	Time	Signature		Date	Time	Signature