Shellharbour Anglican College

Permission to Administer Oral (by mouth) Medication Form

I hereby give permission to College staff to administer the following oral medication to my child:

Student Surname: ______________________________

Student's First Name: ______________________________

Class/Roll Class: ______________________________

Name of Medication: ______________________________

Dose: ______________________________

Frequency: (eg. twice a day) ______________________________

Time: (eg. recess & lunch) ______________________________

Administration in Relation to Food: (eg. before food, with food, not applicable) ______________________________

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If medication is required for more than one day, please specify time period: (eg. Monday, Tuesday & Wednesday or when required for 1 week ______________________________

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MEDICAL INFORMATION

Type of Medication: (eg. antibiotic; analgesic) ______________________________

Reason for Medication: (eg. infection; headache) ______________________________

Please list any possible side effects/adverse reactions: (eg. nausea) ______________________________

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Any other comments/details ______________________________

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Parents requiring administration of oral medication to students by College staff must complete all details on this medication form and hand it in to the College office.

Please ensure that medication is clearly labeled with your child's name, medication name and dosage and frequency instructions in the original container / packet provided by the pharmacist/chemist. Each time medication is administered it is recorded.

I understand that the College accepts no responsibility for any complications arising from the administration of any medication for which I have authorised to be given on my behalf. I release the College from and will indemnify the College in respect to any claim my child may have against the College arising out of complications suffered by my child as a result of such administration of medication.

Parent/Carer/Guardian Signature: ______________________________

Date: ______________________________ **Contact No:** ______________________________