



Shellharbour Anglican College

Permission to Administer Medication Form

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

Student's Surname: _____

Student's First Name: _____

Class/Roll Class: _____

Name of Medication: _____

Dose: _____

Frequency: (eg. twice a day) _____

Time: (eg. recess & lunch) _____

Route: (mouth, eyes, ears or skin) _____

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

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

MEDICAL INFORMATION

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

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

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

Any other comments/details _____

Parents requiring administration of 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 **labelled 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:** _____