TE WAOTU SCHOOL MEDICATION REGISTER

Parent and Staff Agreement for school to administer medication.

Child or Young Person: .....

Child or Young Person's Date of Birth: .....

Group/ Class: .....

Health Condition:
.....

Medical Information

1. Medication name/type (as described on the container):

   .....

Date dispensed: ..... Expiry date: .....or End of Current Year

Dosage and method: .....

……

Times to be given: .....

Special precautions: .....

Side effects: .....

Self-administration: Yes / No / Supervised

Emergency procedures: .....

2. Medication name/type (as described on the container):

   .....

Date dispensed: ..... Expiry date: ..... or End of Current Year

Dosage and method: .....

……

Times to be given: .....

Special precautions: .....

Side effects: .....

Self-administration: Yes / No / Supervised

Emergency procedures: .....

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GP/Health Professional information

Name: .....

Daytime telephone: .....

Parent/Caregiver information

Name: .....

Address: .....

Daytime telephone: .....

Work telephone: .....

Mobile: .....

Relationship to child: .....

Signature - Parent/Caregiver

I …….. (Parent/Caregiver) understand that I must notify the school of any changes in writing. I agree for the school to administer medication.

Signed: ..... Date: .....

Office Procedure

I ……..……. (Office Manager/Principal/Staff Member) understand that a designated staff member must deliver the medication personally to ……..…. (Child/Young Person).

It is agreed that ……..... (Child/Young Person) will receive …….. (quantity and name of medication) every day or as required at ……..……..(time/frequency).

Signature (Office Manager/Principal/Staff Member): ..... Date: .....