PARENT/GUARDIAN'S REQUEST FOR OTEHA VALLEY SCHOOL TO ADMINISTER MEDICATION

I/we request that (child's name)

of (address)

be given medication at Oteha Valley School.

I/we accept that the school does not have a trained medical officer to administer medications.

I/we accept responsibility for the decision to give this medication to my/our child and acknowledge school personnel is in no way responsible for that decision.

I/we also 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.

I/we will notify the school about any changes to dose and recommended time when medication is to be given and fill out a new request form.

Name of Medication		
Dosage and time to be given at school.		
Expiry date of medication (on container).		
Date when medication is to finish.		
Special storage requirements i.e. in fridge etc		
Any side effects of medication.		
Name and Phone No of GP or specialist.		
Parent or guardian's phone number during school hours.		
After Hours Phone No.		
Emergency contact number.		
Signed: Full Name		
Relationship to Child:		Date: