St Monica's Primary School
North Parramatta

NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To be completed by Parent/Guardian,

I request that my child:

Full Name of Student _____

Be allowed to take medication at school according to instructions from:

Full name of Prescribing Doctor: _____

Address of Prescribing Doctor: _____
_____
_____

Phone Number of Prescribing Doctor: _____

The medication has been prescribed for the following reason:

_____
_____
_____

Administration instructions/ Dosage: _____
_____
_____

I hereby give permission to the Principal to obtain relevant information from the Prescribing Doctor.

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medicine. I agree to indemnify the School and related parties on the terms of the attached Deed of Indemnity.

Signed: _____ Date: _____
Parent/Guardian

10 Daking Street North Parramatta 2151
Telephone (02) 9630 3697 Facsimile (02) 9683 4984
Email stmonicasnparra@parra.catholic.edu.au www.stmonicasparra.catholic.edu.au