ALBANY
JUNIOR HIGH SCHOOL

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Auckland 0632

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Date: _____

Permission to Administer Medication at School

I / We request that _____(student name)
of _____(class) be given medication as stated below:

I / We accept responsibility for the decision to give this medication to my / our child and acknowledge the school is in no way responsible for that decision.
I / We accept that the school cannot guarantee that the medication shall be given at a precise time, although every endeavour will be made to do so.
I / We will notify the school nurse of any changes to medication regime, and fill out a new request form.
I / We recognise that the medication is given at my / our request and that any future effects on my / our child is not now, or at any time in the future the school's responsibility.
I / We recognise that the responsibility to provide the school with a supply of medication is mine / ours.

Health Issue: _____ (i.e. Hayfever)
Medication: _____ (i.e. Cetirizine)
Circumstances to be administered:

_____

_____

_____(i.e. Itchy eyes and throat)
Dosage: _____ (i.e.10mg)
Times of administration: _____(i.e. when necessary or 2:00pm)
Duration of administration:

_____

_____(i.e. ongoing or until Sept 5th)
Name and phone number of prescribing Doctor:

_____

Full name of Parent/Caregiver: _____

Relationship to student: _____

Signed by Parent/Caregiver: _____ Date: _____

Signed by School Nurse: _____ Date: _____