AUTHORISATION OF MEDICATION FOR A PUPIL AT SCHOOL

Name of Student: _____ Date of Birth: _____

Please Tick: Prescription Medicine_____ Non-Prescription _____

Prescribing Health Care Clinician & Telephone No.: _____

Medication: _____

Diagnosis/Ailment: _____

Dosage and Frequency (amount to be given and time): _____

Possible Adverse Reactions that should be reported to Parent/ Health Care Clinician:

_____

Special Handling or Storage Instructions: _____

PARENT'S PERMISSION:

I hereby give my permission for my child (named above) to receive the above medication during school hours.

(Please delete as appropriate)

- *This medication has been prescribed by a licensed Physician/Health Care Clinician.*
- *Has been purchased by myself and I give authorisation for you to administer to my child.*

I hereby release Ripley Court School and their employees from any and all liability that may result from my child taking the prescribed medicine.

I understand that all epipens, inhalers and other such medicines kept in school still remain the responsibility of the parents and that I must check on a regular basis that they stay within date and useable.

Signature of Parent/Guardian: _____ Date: _____