If your child has a medical condition, allergy or requires medication that the school needs to hold or know about please complete this form and return to the office. Agreements are required to be completed annually.

ST BRENDAN'S SCHOOL - MEDICATION AGREEMENT

Please supply a recent student photo

Name:	**Room 2018**	

Date of Birth: ___________________________ Parent/Caregiver's Name: _____________________________________

Daytime Number: _______________________ or alternative number: ____

Name of sibling who can be called on in case of emergency**:** ____

Medical / Health Condition Notification ____

My child requires at school the following medication

Name of Medication	
Expiry date of Medication	________/______/__20__________
Side effect of Medication	
Time Medication to be taken	
Dose required	
Date to commence Medication	________/______/__20__________
Date to stop Medication	________/______/__20__________

It is the Parents/Caregivers responsibility to check and renew the supply of all medications.

I/we will notify the school office of any changes to dose, recommended time medication is to be given and update the medication agreement form when necessary. I will also renew all medication on the expiry date as recorded above.

- **All Medication will be taken to the office by a Parent/Caregiver.**
- **Medication will be administered under supervision.**

Parent/Caregiver Medication Authorisation

I accept full responsibility for checking and maintaining supplies, have my child's name, the name of the drug and the correct dose on the container, and that the supplies will not have passed the expiry date.

I/we give permission for a member of the school staff as delegated by the principal to administer the medication according to the instructions above. I/we accept that the school does not have a trained medical officer to administer medications.

I release the school and the school's staff from any responsibility associated with the storage and administration of this medication. I will inform the school in writing if there is any change in the above medication information.

Full Name Parent /Caregiver: _________________________________ **Signature:** ___________________________

Date:_________________________________

School:

*The School will take all reasonable care with the storage and administration of this medication and abide by the Principles of the Privacy Act 1995.

Approved by Principal / or delegated agent:

Name: ____ **Signature:** ______________________________

Date: ____________________________________

For Office / Teacher Use Only

Original copy filed First Aid Register in Office.	*Copy to class teacher for student personal file.*	*Request child's photo.*	*Green Card issued with photo & emergency details. Copy for first aid board & teacher for display.*
☐ **Yes** ☐ **No**	.☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**