St Thomas Aquinas
West Belconnen

FORM 2

Request for Administration of Medication During School Hours

To be completed by Parent or Guardian

I request that my child:

_____

(Full Name of Student) *(Class)*

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

_____

(Full name of Prescribing Doctor)

_____

(Address and phone number of Prescribing Doctor)

The medication has been prescribed for the following reason:

_____

_____

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:

Parent/Guardian _____ *Date* _____