

**VICTORIA AVENUE SCHOOL**  
**ADMINISTRATION OF MEDICINES AT SCHOOL**

Child's name ----- Room -----

Date of birth -----

Parent/Caregiver name -----

Daytime contact number ----- or-----

My child requires the following prescription medication at school:

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Please indicate whether this medication is:

a.) Required to be kept at school longterm.

OR

b.) A one off medication

The medication needs to be taken at ----- (time)

Start date ----- finish date/ expiry date -----

I accept full responsibility for maintaining supplies, having 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 give permission for a member of the school staff to administer the medication according to my child's needs as indicated above and accept that this may not be the same staff member each time. I accept that the school will take due care with the administration of the medication but I release the school and the school's staff from any responsibility associated with it. I will inform the school in writing if there is any change to the above medication information. The school will accept responsibility for keeping the information in a safe place.

Full name -----

Signature -----

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