ST MARY'S PRIMARY
RYDALMERE

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NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To be completed by the parent or guardian

I request that my child _____
Full name of Student

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: _____ **Date:** _____
Parent/Guardian