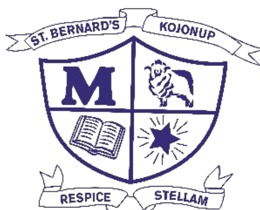

ST. BERNARD'S CATHOLIC PRIMARY SCHOOL

STUDENT MEDICATION FORM

.

STUDENT'S NAME……………………………………………………………….. DATE OF BIRTH ……………….…

PLEASE COMPLETE FULLY AND CAREFULLY

PARENT / CARER ……………………………………………..……………………………………………….

ADDRESS ………………………………………………………………………………………………………

TELEPHONE (HOME). …………………..(WORK)…………………………… (MOBILE)……….….………………………..

ALTERNATIVE EMERGENCY CONTACT & NUMBER……………………………………..…………………………

FAMILY DOCTOR ……………………………………………...………… CONTACT No.………………...……………………..

FAMILY DENTIST ……………………………………………...………… CONTACT No.………………...……………….……

MEDICAL CONDITIONS…………………………………………………………………...…………………………

……

NAME OF MEDICATION (S) (1).………………………………………...………………………………...…………

(2).……………………………………………………………………………………….

PURPOSE OF MEDICATION……………………………………………………………...…………………………

DOSAGE OF MEDICATION……………………...………………………………………...…………………………

PROVIED SPECIFIC DIRECTIONS FOR ADMINISTRATION……………………………………...…………………………

……

FREQUENCY…………………………………………….TIME(S) OF ADMINISTRATION……….…………………………..

POSSIBLE SIDE EFFECTS…………………………….……………………………………...…………………………

Please note wherever possible, medication should be scheduled at times other than school hours

ALL MEDICINES ARE TO BE CLEARLY LABELLED AND HANDED TO ADMINSTRATION

PARENT CONSENT I GIVE PERMISSION FOR THE PERSON IN CHARGE OR HIS/HER REPRESENTATIVE TO ASSIST WITH THE GIVING OF PRESCRIBED MEDICATION FOR MY CHILD AND I UNDERSTAND THAT I AM RESPONSIBLE FOR THE DETAILS ABOVE BEING TRUE AND CORRECT. I FURTHER AUTHORISE QUALIFIED MEDICAL PRACTITIONERS TO ADMINISTER ANAESTHETIC AND/OR BLOOD TRANSFUSION AND TRANSPORT, IF NECESSARY. I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT ME BEFORE THE ABOVE IS PUT INTO PLACE.

PARENT / CARER SIGNATURE …………………………………………………………………………………….

PARENT / CARER NAME ……………………………………………………DATE. ……………………………..…..