ASHLYNS SCHOOL

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ASPIRE & ACHIEVE

REQUEST FOR SCHOOL TO STORE MEDICATION MED 1

The school will not store medicines for your child to take unless we have your written permission on this form.

DETAILS OF STUDENT

Surname: ______________________________

Forename(s): ______________________________

Address: ______________________________

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Male/Female: __________ Date of Birth: __________ Form Group: ______________

Medical condition / illness: ______________________________

MEDICATION

Name/Type of Medication: ______________________________
(As described on the container)

For how long will your child take this medication: ______________________________

Date dispensed: ______________________________

Full Directions for use:
Dosage and method:______________________________

Timing: ______________________________

Special Precautions: ______________________________

Side Effects: ______________________________

Self-Administration: ______________________________

Procedures to take in an Emergency: ______________________________

CONTACT DETAILS

Name: ____________________ Relationship to Pupil: ______________

Address: ______________________________

____________________ Daytime Telephone No: ______________

I understand that I must deliver the medicine personally to the School Office and accept that this is a service which the school is not obliged to undertake. I understand that parents are responsible for noting medication expiry dates and replenishing the school held medication when required. Ashlyns School will not be held responsible for checking expiry dates on ANY medication, including Epipens.

Date: ____________________ Signature(s): ____________________