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

To be completed by Parent or Guardian.

I request that my child.....Class.....

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

Prescribing Doctor/Address and phone number.....

.....

Name of medication and dosage.....

The medication has been prescribed for the following reason:

.....

.....

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 hereby indemnify and agree to keep indemnified the Catholic School and its employees and agents, and St. Joseph's Primary School, Wagga Wagga and its employees and agents, including the teachers and other staff of the school, from and against all actions, suits, claims, demands, complaints and causes of action (including for or in respect of death, personal injury or any alleged infringement of the rights of any person) and the costs thereof in respect of or arising directly or indirectly out of such administration of medication.

Signed by:

.....Date.....

Parent/Guardian

In the Presence of.....

Signature of Witness

.....Date.....

Name of Witness (please print)