Trinity Grammar School

Request from Parents/Guardians for the School to Administer Medication to a Student

Date of Request: .....

Student Surname: ..... Student First Name: ..... Year: ..... Hse: .....

Medical Practitioner: ..... Medical Practitioner's Phone Number: .....

Health/Medical conditions: .....

Could your child experience an emergency reaction in relation to this condition (tick one): Yes: ☐ No: ☐

Name of medication: ..... Prescribed for (name of condition): .....

Prescribed dosage: .....

(Note: All prescription medications need to be supplied in their original container with pharmacy label)

Dates to be given medication: ..... Times to be given medication: .....

Special storage instructions, if any (eg. refrigeration): .....

Special instructions for administration (eg. taken with food): .....

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication (tick one box)?

Yes: ☐ No: ☐ If yes, please provide more information: .....

If your child administers his own medication at home, do you request that he administers this medication at School (tick one box)?

Yes: ☐ No: ☐ If your child administers the medication at home, what level of support do you provide?

.....

Name of person who will carry the medication to School: .....

Any other requests for support? .....

I authorise Trinity staff to administer the medication(s) detailed above to my child.

Parent/Guardian Name: ..... Emergency Phone Number: .....

Parent/Guardian Signature: ..... Date: .....

Please return this form to the School's Nurse at Summer Hill, Strathfield & Pine Bluff, or the Receptionist at Lewisham

Record of Administration (School Use Only)

Date	Time	Signature		Date	Time	Signature