

# Daily Medication Request - 2017



Parent/Carer authorises this medication to be given daily

Medication must be provided in its original packaging, labelled with the student's name.

**Please indicate the length of time this medication is to be given:**

- Short term** medication request - will lapse after seven (7) days from request date.
- until medication provided is finished     
  specific number of days: .....
- Long term** medication request - will lapse on 8th December 2017.

Student Details		
<b>First Name:</b>	<b>Surname:</b>	<b>Grade:</b>
Medical condition/s:		
Medication allergy:		

Medication Provided by Parent/Carer
Medication name:
Reason for medication:
Dose to be given:
Time to be given:
Specific instructions:

Medication Prescribed by	
Name of prescribing Doctor:	Date prescribed:
or <input type="checkbox"/> Medication initiated by Parent/Carer	or <input type="checkbox"/> Medication initiated by Pharmacist

Medication Storage
Medication to be stored in clinic: <input type="checkbox"/> fridge    or <input type="checkbox"/> cupboard
After school, medication will be:
<input type="checkbox"/> left in clinic <input type="checkbox"/> collected by parent or student <input type="checkbox"/> sent to OOSH

Signed Consent
I understand that William Carey Christian School accepts no responsibility for any complications arising from the administration of medication, for which I have given authority to be given on my behalf. I release the school from and will indemnify the school in respect to any claim my child may have against the school out of complications suffered by my child as a result of such administration of medication. I understand it is the responsibility of the Parent/Carer to advise WCCS when the medication is no longer to be given.
<b>Parent/Carer signature:</b> _____ <span style="float: right;"><b>Date:</b> _____</span>

<b>Office Use-</b> Medication request received: <input type="checkbox"/> WCCS request form <input type="checkbox"/> written request <input type="checkbox"/> verbal request
Medication ceased date: _____                          Request to cease received: <input type="checkbox"/> as per form <input type="checkbox"/> written <input type="checkbox"/> verbal

