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

- **First Name:**
- **Surname:**
- **Grade:**

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:**

- [ ] Medication initiated by Parent/Carer  or  [ ] Medication initiated by Pharmacist

### Medication Storage

- **Medication to be stored in clinic:**
  - [ ] fridge  or  [ ] cupboard

After school, medication will be:

- [ ] left in clinic
- [ ] collected by parent or student
- [ ] 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.

**Parent/Carer signature:** ____________________________  **Date:** ____________________________

### Office Use

- **Medication request received:**
  - [ ] WCCS request form  
  - [ ] written request  
  - [ ] verbal request

- **Medication ceased date:** ____________________________

- **Request to cease received:**
  - [ ] as per form  
  - [ ] written  
  - [ ] verbal
Parent/Carer authorises this medication to be given daily

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<th>Date</th>
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