



# HARBORD PUBLIC SCHOOL

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OLIVER STREET, HARBORD 2096  
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## Administration of Medication at School

Date: .....

Student Name: ..... Class: .....

Medication to be administered: .....

Is this a prescription medication:      Yes / No *(please circle)*

Dosage: .....

Time(s) to be administered: .....

For .....Days (or) until further notice *(please circle)*

I, ..... (Parent / Caregiver), give permission for Harbord Public School to administer the prescribed medication to my child as outlined above.

In the case of long term medication, I will inform the school in writing when medication is to cease or change.

I understand that all medication must be brought to the administration block for safekeeping. Medication is not to be kept in the students' bag or classrooms.

I understand that Administration Officers will supervise the administration of the medication, but will not be responsible for ensuring the student comes to the office. It is therefore recommended that parents or caregivers also inform the class teacher that medication is required.

Signed: ..... (Parent / Caregiver)

Request Approved: ..... (Principal)

