

## CONSENT TO ADMINISTER MEDICATION

Student's name: \_\_\_\_\_

Atawhai group: \_\_\_\_\_ DOB: \_\_\_\_\_

Health condition/reason for medication:

\_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time/s medication to be administered: \_\_\_\_\_

Duration medication to be administered (e.g. 7 days): \_\_\_\_\_

Side effects/special precautions with medication: \_\_\_\_\_

Any other details: \_\_\_\_\_

- I give permission for the school first aider or other designated staff member to administer this medication according to the written medication instructions above.
- I accept full responsibility for maintaining supplies, having the student's name, name of drug and correct dose on the container and that supplies will not have passed the expiry date.
- I accept that the school will take due care with the administration of this medication, but I release the school and the school staff from any responsibility associated with it.
- I will inform the school in writing if there is any change in the above medication information.
- The school will accept responsibility for keeping this information safe.

\_\_\_\_\_  
Parent/Caregiver name

\_\_\_\_\_  
Parent/Caregiver signature

Date: \_\_\_\_\_