Dear

Please find attached the forms that need to be completed so that antibiotics can be administered to ________________________________ during the school day.

These forms comply with the procedure recommended by the Catholic Schools Office and have been designed to ensure the safety of your child and to protect the school staff who do not have medical training.

I am aware that this may seem a complicated process but please be assured that the school will give you every assistance in this matter.

As an interim measure only, we have administered the antibiotics today, however we will be unable to administer any further medication without the required documentation.

Please do not hesitate to contact me if I can be of further assistance to you.

Yours sincerely,

[Signature]

Mr Barry Shanley
Principal
NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To be completed by parent or guardian

I request that my child ____________________________________________ be allowed to take medication at school according to instructions from ____________________________________________ (Full Name of Prescribing Doctor)

Address of prescribing doctor: ____________________________________________

Contact number: ____________________________

The medication has been prescribed for the following reason:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I hereby give permission to the Principal to obtain relevant information from the prescribing doctor. I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medicine. I agree to indemnify the school and related parties on the terms of the attached Deed of Indemnity.

Signed: ____________________________________________ Date: ________________
DEED OF INDEMNITY

In consideration of the members of staff of ST. JOHN FISHER CATHOLIC SCHOOL at my request administering medication to my son/daughter ________________________________

I hereby indemnify and agree to keep indemnified the Catholic Schools Office and its employees and agents, including the teachers and other staff of the school, from and against all actions, suits, claims, demands, complaints and causes of action (including for or in respect of death, personal injury or any alleged infringement of the rights of any person) and the costs thereof in respect of or arising directly or indirectly out of such administration of medication.

Signed, sealed and delivered by the said: ________________________________ (parent/guardian)

In the presence of: ________________________________ (signature of witness)

Name of witness (please print): ________________________________

Date: ________________________________
FORM 3

MEDICAL ADVICE TO SCHOOL

To be completed by prescribing doctor

Student's full name: ________________________________

1. Medical condition(s) of the child requiring regular treatment:

________________________________________________________________________

________________________________________________________________________

2. Essential medication requiring administration during school hours:

Medication Details

<table>
<thead>
<tr>
<th>Condition name</th>
<th>Medication name</th>
<th>Dosage</th>
<th>Time/s of administration</th>
<th>Special instructions</th>
<th>Self-administration (yes/no)</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

3. Recommended restrictions on participation in school activities (e.g. sport, use of tools or machinery):

________________________________________________________________________

________________________________________________________________________

4. Recommended procedure in crisis situation

________________________________________________________________________

________________________________________________________________________

5. Additional comments:

________________________________________________________________________

________________________________________________________________________

Signature of prescribing doctor: __________________________ Date: __________