CATHOLIC SCHOOLS Broken Bay	**Request to Administer Medications at School**		
School name	**ST JOHN FISHER PRIMARY SCHOOL TUMBI UMBI**		
Name of Student			
Date of Birth		Year Level	

Please list all the medications the student requires during school hours and any emergency medications as indicated on the student health care plan.

Notes:

1. *If the medication (Ritalin, antibiotics), including **over-the-counter medication**, is within its original container and has the pharmacy label attached and lists the prescribing Doctors name, patients name, prescription number, how to take the medication, the name of the medication and quantity, the date the medication was filled, pharmacy details and phone number, this form **does not** require the signature of the prescribing health practitioner.*
2. *If the above information is not on the approved pharmacy label attached to the medication, then an authorised medical professional will need to sign this form.*
3. *For over-the-counter medication required for a short period of time, such as **Panadol, Nurofen** or **Claratyne**, complete this form, but it is not required to be signed by a medical professional.*

Name of Medication	**Strength (e.g. 5 mg)**	**Dosage (e.g. 1 tablet)**	**Route of Administration (e.g. Oral, via the nose)**	**Time to be given at school**	**Other important instructions (e.g. storage instructions or student self-administers medication)**

I request that school staff administer the necessary medication to this student while at school. I confirm the above information provides the school with the complete and necessary information to administer the medication. I also understand and agree that it is my responsibility (parent/guardian) to inform the Principal of any medication administration changes and will do so in writing as specified in the CSBB Administration of Medications in Schools Procedure.

Parent/Guardian Name			
Signature			
Phone number		Date	

This authorisation applies to the period of start date: end date:

Authorising Practitioner:

Print Name			
Signature		Date	

Medical practice stamp:

Office Only: When this course of medication concludes, please retain this form in the student's school file.