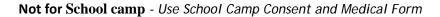
Consent to administer MEDICATION at school.

Includes OSHC





Student Full Name:				Photo (if desired)
Year Level				
Date of birth:				
Address:				
——————————————————————————————————————				
Asthma Reliever		_	y the PARENT for blue colon" to be completed.	oured inhaler ONLY.
			s than 30 days: from ation must be prescribed b	
This form MUST be com	pleted and sign	ed by the [more than 30 days fro DOCTOR – a new form is Asthma, Epilepsy or D	•
Paracetomol (e.g. Panada medical practitioner ar				en prescribed to the student b
Medicare Card Number: Card Expiry date/	:	Posit	ion (the number next to individ	lual's name):_
1. Medical condition(s) c	of the child requ	iring regular	treatment:	
2. Essential medication r	equiring admini	stration duri	ng school hours: (including	g OSHC)
Medication Name	dosage	Time/s of dosage	Special Instructions	Self-admin (Yes/No)
				, , ,
3. Recommended restric	tions on partici	pation in sch	ool activities (e.g. sport, u	se of tools or machinery):

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4. Recommended procedure in crisis situation:				
5. Addi	tional comments:			
Conse	nt by parent:			
	I understand it is my responsibility to pread to ensure its immediate replenishmed understand medication label must be in relevant to request period) For asthma puffers & paracetamol this find date of expiry (whichever is sooner). I understand that the information proving members of school staff. I hereby give permission to the Principal information from the Prescribing Doctor. I agree to collect any unused or expired home with student). I authorize the school to provide to amb practitioner(s) information concerning a laccept and agree to observe the condinagree that it is my responsibility to information. I understand medication may be adminimedical training.	covide the medication and equipment for its administration, then after use, or when it requires replacement. It is sued for this event period (i.e. date on packaging must be corm is valid up to December 31 of the current year or until ded may be discussed by the Principal/or delegate with other incipal/or delegate, at their discretion, to obtain relevant remedication from the school. (Medications will not be sent oulance / hospital authorities or qualified medical any of the medications or conditions identified above. It ions imposed by the school (workplace) and understand and form the Principal of any changes involving the administration distered by a school staff member who may not have received eted in accordance with my child's current Asthma		
Na Da	gnature of Parent/Guardian: ame ate: ontact No.			
	MEDICATION prescribed for more than 3 doctor.	0 days? If yes, this form MUST also be signed by your		
Na M Da	gnature of Doctor: ame edical Practice: ate: ontact No.			
Accept	ed by Principal / Delegate:	Date:		

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