REQUEST TO ADMINISTER MEDICATION – YR 9 CAMP

Student Name: _____ Date of Birth: / /

Allergies: _____ Class: _____

Please list all medications that your child requires during camp (if more than one please see over).

Staff Member Administering to Sign Below:

Name of Medication	**Parents to complete**	**7 September Administered by - please sign**	**8 September Administered by - please sign**	**9 September Administered by – please sign**	**10 September Administered by – please sign**
Strength (eg. 10mg)					
Dosage (eg. 1 tablet)					
Route (eg. oral)					
Time/s to be given AM					
Time/s to be given AM					
Time/s to be given PM					
Time/s to be given PM					
Other useful instructions or information					

I hereby request that College staff administer the necessary medication to my child whilst on camp.

Parent/Carer (please print): _____

Signature: _____ Date: / /

NOTE:
For **staff** operating under direction of the Head of College to administer medication to a student, authorisation is required from a medical practitioner/parent.

- **Provide any regular medication in pharmacy Webster Pack.**
- For last minute medication such as antibiotics not in a webster pack, please ensure medication is in date and has an original pharmacy label with the **student's name**, dosage and time/s to be taken.
- The student has received a dose at home without any noted side effects prior to attending camp.

ALL MEDICATION FOR STUDENTS MUST BE HELD AT ALL TIMES BY THE SUPERVISING TEACHER (EXCLUDING THOSE MEDICATIONS ACCOMPANYING AN ACTION PLAN)

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