Medication Authorisation and Disclaimer Form

For regular use of prescribed medication at school

I/We ..... caregivers of ....., Whānau Group: ..... wish for her to receive prescription medication at school on a regular basis as outlined by the prescribing Doctor.

Name(s) of the Medication: .....
Dosage: .....
Prescribed by: .....

1. Attached to this form is written verification of the need for the medication and the correct dosage and possible side effects from the prescribing Doctor.

2. We are aware that the Board of Trustees and its employees will not accept any responsibility for accidental or incorrect dosage, the failure by the student to take her medication when prescribed or claims for any long-term side effects.

3. We are aware that it is our daughter's responsibility to arrive at the office/health centre at the appropriate time to receive the medication. When the medication expires, contact will be made with home for the medication to be picked up/replacement requested.

4. We ask that our daughter take her medication (time of day).....

5. I/We acknowledge receipt of a copy of the Board of Trustees current policy on medication and its administration and confirm that I/We have read and understood this policy.

Signed: ..... **Date:** ...../...../20.....