Request for the Administration of Medication

To be completed by Parent or Guardian

I request that my child: _____(*Child's full name),*

DOB: _____ *Days Attending:* *am M T W TH F*

Pm M T W TH F

be allowed to take medication at the OOSH Centre according to instructions from:

_____*(Full Name of Prescribing Doctor)*

_____*(Address and Telephone number of Prescribing Doctor)*

This medication has been prescribed for the following reason (optional): _____

MEDICATION DETAILS

Medication Name	Dosage	Volume	Method of administration	Special Orders	Self administration (Yes or No)

I understand that depending on the nature of the medication, the Centre Coordinator may need to obtain relevant information from the Prescribing Doctor. Should this be the case, I agree to complete the relevant forms, which will be provided by the Centre.

I accept and agree to observe the conditions imposed by the Centre and understand and agree that it is my responsibility to inform the Coordinator of any changes involving the administration of the medicine. I agree to indemnify the Centre and related parties on the terms of the attached Deed of Indemnity.

Signed: _____ Date: _____

(Parent/Guardian)