St Peter’s Primary School

Authorisation for the Administration of Medication during school hours

To be completed by Parent or Guardian

I/We hereby authorise St Peter’s Primary School to administer the following medication

________________________________________________________

(Name of Medication and Dosage)

to my/our child _____________________________ Class __________

(child’s name)

Date Medication to be taken / / until / /

Medication time will be at 11.30am (after lunch 1 bell)

I/We accept and agree that it is my/our responsibility to inform the school of any changes to the administration of the medication.

Deed of Indemnity
I hereby indemnify and agree to keep indemnified the Catholic Schools office and its employees and agents, and St Peter’s Primary School Port Macquarie and its employees and agents, including the teachers and staff of the school, from and against all actions, suits, claims, demands, complaints and causes of actions (including for or in respect of death, personal injury and any alleged infringement of the rights of any person) and the costs thereof in respect of or arising directly or indirectly out of such administration of medication.

Signed ___________________________ Date __________

(Parent/Guardian)

Name : _____________________________

(Parent / Guardian)