



BOARDERS ONLY

Permission For Administration Of Medication

I, _____ (Parent's/Guardian's Full Name)

hereby give permission for Health Centre and Senior Boarding staff to administer medications to my son/daughter,

_____ (Child's Full Name)

The following non-prescription/over the counter medications are held in the Health Centre for the relief of minor pains, coughs, colds and fever.

PLEASE TICK MEDICATION AUTHORISED TO BE GIVEN TO YOUR SON/DAUGHTER IF REQUIRED.

Paracetamol (pain/fever)

Loratadine (antihistamine e.g. claratyne)

Ibuprofen (pain / fever)

Sudafed PE (cold medication)

Cough suppressant

Mylanta (antacid)

Cough expectorant

If you prefer that your son/daughter receive alternative medication to the above, please contact the Health Centre to discuss your individual needs. Email healthcentre@lcgs.tas.edu.au or phone 6336 6033

Regular/Prescription Medication:

Conditions which require regular/prescribed medications **MUST** be signed by a **DOCTOR AND PARENT/GUARDIAN.**

Changes must be made in writing to the school. (Please print this form and return a signed copy)

Medication **MUST** be supplied in the original container and labelled with the student's name and required dosage.

MEDICATION	DOSAGE	TIME OF ADMIN.	SIDE EFFECTS	SELF ADMIN.

Signed (Doctor): _____ Signed (Parent/Guardian): _____

Name (Doctor): _____ Name (Parent/Guardian): _____

Date: ____ / ____ / _____

Date: ____ / ____ / _____

Dental

Do you wish your child to have regular dental checks? YES NO OR Emergencies Only

The Practice the School uses is: Dr. Pickup and Associates, 44 Brisbane Street, Launceston 7250

IF OTHER please specify:

Medical / Surgical History

Relevant medical/surgical history:

Diet

Any special requirements:

Emergency Medical Care

I, _____ *(Parent's/Guardian's Full Name)*

Give permission for either: School Nurses
Head of Boarding
A senior staff member

Acting in **LOCO PARENTIS** (on behalf of the parents) to sign authorisation forms for my son/daughter,

_____ **(Child's Given Name and Family Name)**

for any necessary emergency anaesthetic or medical treatment.

By submitting this form I declare that all of the information is complete and correct.

Parent/Guardian Name: _____

Phone Contact: _____

Date: ____ / ____ / ____