Brooklyn School Est. 1883
Take up the challenge - Mauria te taki

MEDICAL CONDITION/ALLERGY & AGREEMENT

Child's Name: _____Room/Class/Area_____

Parent/Caregiver's Name: _____ _____

Daytime Contact Number/s: _____ _____

Doctor: _____ **Medical Practice:** _____ **Tel:** _____

MEDICAL CONDITION:

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TRIGGERS:

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SYMPTOMS DISPLAYED:

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TREATMENT REQUIRED IF SYMPTOMS APPEAR:

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Will medicine be required to treat symptoms? ☐ Yes ☐ No

If ☑ Yes:

Can the child administer the medication themselves? ☐ Yes ☐ No

Is the medication to be kept in the child's school bag/classroom? ☐ Yes ☐ No

Is the medication to be kept in the office strongroom/staffroom fridge ☐ Yes ☐ No

Medicine: ..... Dose: ..... Frequency: .....

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Is there any other information that may be useful to the school regarding the students condition or medication?

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I accept full responsibility for:

- maintaining supplies, having my child's name, the name of the drug and the correct dose on the container, and that the supplies will not have passed the expiry date.

I give permission for:

- a member of the school's staff, as delegated by the principal, to administer any medication according to the instructions above

I release the school and the school's staff from:

- any responsibility associated with the storage and administration of this medication.

I will inform the school in writing if there is any change in the above medical information

Name _____
Parent/Caregiver

Signed _____ _____
Parent/Caregiver **Date**

School

The school will keep records according to the principles of the Privacy Act 1995
The school will take all reasonable care with the storage and administration of any medication

_____ _____
Approved by Principal **Date**