Endeavour School

To endeavour, to succeed

Kia Tūkaha, Kia eke

CONSENT FOR MEDICINE TO BE GIVEN AT SCHOOL

STUDENT NAME _____ **DATE** _____

Student's Learning Community or Ako Group _____

Medicine (name) _____

Dosage (amount) _____ **Frequency** _____

Special requirements _____
(*eg; to be taken with / without food*)

Start Date _____ **Stop date** _____ **OR**

☐ **Medication to be kept at Endeavour School permanently (please tick)**

Declaration:

1. *I give my consent and approve that nominated staff at Endeavour School administer the medication I have provided.*

2. *I accept that staff at the school will administer the above noted medication in accordance with the medical practitioner's directions on the package or bottle.*

3. *I understand that Endeavour School Staff are not trained Health professionals and will administer the medication to their best of their ability.*

Parent/Caregiver Name _____

Parent/Caregiver Signature _____

MEDICATION RECORD SHEET

DATE	TIME	DOSE	STAFF SIGNATURE	STAFF NAME