Appendix 1.

MEDICATION AGREEMENT

Houghton Valley School

Name of Student: _____ Room: _____

Parent/Caregiver's Name: _____

Phone Contacts: Home _____ Daytime _____ Emergency _____

Medical Practitioner: _____

USE THIS TABLE IF MEDICINE IS TO BE TAKEN AT PRESCRIBED TIMES/DOSAGES

Medical Condition	Medicine to be administered	Dosage	Time/s to be taken

USE THIS TABLE FOR AMELIORATIVE OR PREVENTATIVE MEDICINE

Medical Condition	Medicine to be administered	Dosage	State under what conditions medicine is to be taken	Tick if you require the taking of this medication to be recorded

Start Date: _____ Finish Date: _____

Other Instructions:

_____

I certify the information given above is correct. I authorise Houghton Valley School to be responsible for the administration of medicines taken by above named pupil. I understand that the taking of this medication may be supervised by any Houghton Valley staff member who will supervise the taking of medicines according to the labelled instructions listed above.

Signature of Parent/Caregiver: _____ ***Date:*** _____

Signature of Office Manager: _____