

# Daily Medication Request - 2025



Parent/Carer authorises this medication to be given daily in 2025

Medication must be provided in its original packaging, labelled with the student's name.

Please indicate the length of time this medication is to be given:

**Short term** medication request - will lapse after seven (7) days from request date.

until medication provided is finished OR  specific number of days: .....

start date: ..... end date: .....

**Long term** medication request - will lapse on 11th December 2025

**WILLIAM CAREY  
CHRISTIAN SCHOOL**

Student Details		
<b>First Name:</b>	<b>Surname:</b>	<b>Grade:</b>
Known medical condition/s:		
Medication allergy:		

Medication Provided by Parent/Carer
Medication name:
Reason for medication:
Dose to be given:
Time to be given:
Specific instructions:

Medication Prescribed by	
Name of prescribing Doctor:	Date prescribed:
or <input type="checkbox"/> Medication initiated by Parent/Carer	or <input type="checkbox"/> Medication initiated by Pharmacist

Medication Storage	Staff Use-					
Medication to be stored: <input type="checkbox"/> in fridge or <input type="checkbox"/> at room temperature	<input type="checkbox"/> cupboard or <input type="checkbox"/> S8 / S4 safe					
After school, medication will be:	Notes:					
<input type="checkbox"/> left in Health Centre	Notes:					
<input type="checkbox"/> collected by parent or student						
<input type="checkbox"/> sent to OOSH	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; border: none;">Mon</td> <td style="width: 20%; border: none;">Tues</td> <td style="width: 20%; border: none;">Wed</td> <td style="width: 20%; border: none;">Thurs</td> <td style="width: 20%; border: none;">Fri</td> </tr> </table>	Mon	Tues	Wed	Thurs	Fri
Mon	Tues	Wed	Thurs	Fri		

Signed Consent	
I understand that William Carey Christian School accepts no responsibility for any complications arising from the administration of medication, for which I have given authority to be given on my behalf. I release the school from and will indemnify the school in respect to any claim my child may have against the school out of complications suffered by my child as a result of such administration of medication. I understand it is the responsibility of the Parent/Carer to advise WCCS when the medication is no longer to be given.	
<b>Parent/Carer signature:</b>	<b>Date:</b>

Staff Use-	
Medication request received: <input type="checkbox"/> WCCS request form <input type="checkbox"/> written request <input type="checkbox"/> verbal request	
Medication ceased date:	Request to cease received: <input type="checkbox"/> as per form <input type="checkbox"/> written <input type="checkbox"/> verbal

