# MEDICATION SCHEDULE

*Please pay specific attention to any clause in red or **bold**! These clauses either require an acknowledgement by you, you are taking on any risk or liability or limiting the risk or liability of the School or you are indemnifying the School. Please read this Medication Schedule carefully and ask if you have any questions!*

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|---|---|---|---|---|---|---|---|---|---|---|
| Full names and Surname of Child: | | | | | | | | | | |
| Date of Birth: | D | D | M | M | Y | Y | Y | Y | Age: | |

| Details: | Mother's/Guardian's | Father's/Guardian's |
|---|---|---|
| Name: | | |
| Surname: | | |

| Doctor's Details: | |
|---|---|
| Name: | |
| Surname: | |
| Practise Name: | |
| Contact Number: | |

| CHRONIC MEDICATION: | QUANTITY: | TIME: |
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*While the School shall use its best endeavours to ensure that the medication is administered, the correct medication and/or amount of medication is administered to the Child in accordance with the Medication Schedule and/or the Medication Register, the School shall, to the extent permitted by law, not be liable under any circumstances whatsoever for any claims for, including but not limited to any loss, injury, illness, death and/or damages, to the person and/or property of the Child, and/or to the person and/or property of his/her Parent/Guardian whilst being in the care of the School, which care includes but is not limited to the administration of medication requested to be administered to the Child by the Parent/Guardian, unless such loss, injury, illness, death and/or damages arise as a result of gross negligence on the part of the School.*

Signature of Guardian: _____ Date: D D M M Y Y Y Y