Medication Authority Form

CHILD’S DETAILS
Child’s Name: __________________________________________ Grade: _____
Name of Medication: _______________________________________________________
Reason for Medication: _____________________________________________________

Type of Medication: (please tick)
- Tablet/Capsule  - Elixir  - Drops  - Cream  - Other: __________________________

Dosage (Amount to be given): _______ Time of previous dose (i.e. at home): _______

Frequency (Time to be given):
- Morning Recess (11.00am)
- Lunchtime (1.30pm)
- Other: __________________________

Duration:
- This medication is for today only: Date ___________
- This medication is ongoing from ___________ to ___________

PARENT/GUARDIAN’S DETAILS
Parent/Guardian’s Name: ___________________________________________________

I hereby authorise the staff of St Paul Apostle North Primary School to administer medication to my child as detailed above.

I understand that
☑ students are not permitted to keep tablets or medications in their bags
☑ the medication will only be given if it is in its original container
☑ prescription medication is specifically prescribed for the child named on this form
☑ medications must be handed into the office/classroom teacher in the morning, and collected at the end of the day by a parent/guardian

Signature: _______________________ Date: ______________

STAFF TO COMPLETE
Date: __________ Dose Given: __________ Time: ______________

Staff Name (print): ___________________________ Staff Signature: __________________

Witness (print): ______________________________ Signature: __________________

Please complete the back of this form for ongoing medications