

MEDICINE AUTHORITY FORM

Child's Name

Date / /

Class Teacher

Room/Level

I request that my child be given the following medication:

NAME OF MEDICINE AND DOSE

TIME(S) WHEN MEDICINE IS GIVEN

PROCEDURE FOR GIVING MEDICINE

CONDITION FOR WHICH MEDICINE IS GIVEN

Name of prescribing doctor

I accept responsibility for:

- the decision to give this medication to my child, and acknowledge that the school is in no way responsible for that decision, now or in the future
- notifying the school about any changes in dosage, time, or procedures, by filling out a new Medicine Authority form
- delivering the medication personally to school.
- ensuring that the medicine is not past its expiry date.

I accept that the school:

- may not have a trained medical officer to administer medications
- cannot guarantee that medication will be given at a precise time or by the same person.
- will dispose of any uncollected medicine at the end of the year.

Parent/guardian's name

Signature

Date / /