

SHORT TERM/INFREQUENT MEDICATION AUTHORISATION FORM

For example: Anti-allergy, Asthma medications / Antibiotics / Panadol when provided to the school. I authorise the Nurse, Office Staff, Teacher, or After Hours Staff in charge to administer the following medication to my child: Student's Name: _____Grade: ____ Medication: _______Dose: _____ Dates to be given:_____ Times to be given:_____ Signed:_____(Parent/Guardian) Date:____ Mobile phone no.:______ Work phone no.:_____ FOR YOUR CHILD'S SAFETY PLEASE ENSURE THAT ALL MEDICATION REQUIRED IS SUPPLIED IN ITS ORIGINAL CONTAINER AT THE TIME OF NOTIFICATION AND IS WITHIN THE EXPIRY DATE Further comments_____ Signed: _____ (Treating Doctor)

RECORD OF TIME GIVEN (for school use only)

Date	Time	Signature	Date	Time	Signature
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