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** / /

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