PERMISSION FOR THE
ADMINISTRATION OF MEDICATION

BEFORE MEDICATION IS ADMINISTERED BY SCHOOL STAFF THE FOLLOWING MUST BE COMPLETED:

1. This permission form.
2. Medication MUST BE LABELLED CLEARLY stating:
   (a) the name of the child
   (b) the dosage, dates and times for it.

PLEASE ASK YOUR PHARMACIST FOR THIS INFORMATION WHEN MEDICATION IS ISSUED.

Please note: Analgesics, cough mixture and the like will not be administered, unless permission is given by a parent or guardian.

PARENT/GUARDIAN AUTHORITY FORM FOR THE ADMINISTRATION OF MEDICATION

I hereby authorise medication to be administered to my child.

CHILD’S NAME: __________________________________________________________
MEDICAL CONDITION: ____________________________________________________
MEDICATION: __________________________  Dosage: _______________________
DOCTOR WHO PRESCRIBED: ____________________________________________
DATES FOR ADMINISTRATION: _____________________________________________
TIME/S FOR ADMINISTRATION: ____________________________________________
UNUSED MEDICATION RETURNED TO PARENT/GUARDIAN: YES  NO

PARENT’S/GUARDIAN’S NAME: _____________________________________________
  Home Ph: __________________  Work: ______________  Mobile: ______________
Signature of Parent/Guardian: ____________________________________________
  Date: ______________
Principal/First Assistant: ________________________________________________
  Date: ______________

*N.B. If your child suffers from asthma please ensure that a copy of your child’s asthma plan is attached.