Inspire - Learn - Lead

MEDICINE AUTHORITY FORM

Student's name : _____

Class teacher : _____

Room / Year : _____ Date : _____

I request that my child be given the following medication: (name of medication)	
Dosage and time(s) when medicine is given	
Condition for which medicine is given?	
Date when medication is to finish	
Special storage requirements	
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:

- Does 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
- It is the student's responsibility to come to the office at the appropriate time
- Will dispose of any uncollected medicine a the end of the year

Parent/guardian's name:	

Signature	

Date	