

MEDICATION AUTHORITY FORM

**NB:** Parent/caregiver to complete this form and sign to indicate they agree to the conditions outlined on this form.

**Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room No.: \_\_\_\_\_**

**Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name/Type of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dose (exact amount required and time): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please note:**

1. In the case of regular administration of some medicines, eg asthma, your child may be independent and able to manage their own medicine administration.
2. Whenever possible, medication is administered by the Office Manager. The person administering medication may not have medical experience.
3. The school takes every care to ensure the student receives the prescribed medicine. However, we cannot guarantee this and accept no responsibility for doses missed or wrongly administered.
4. **Medicine must be sent to school in the original container with the pharmacy name, medication and dosage frequency details on the container.**
5. A record is kept of all doses administered at school.
6. Any changes in dosage or frequency of administration must be notified to the school in writing.
7. The school reserves the right to decline or discontinue administering medication at any time. Parents are advised first in the likelihood of this decision being made.

**I UNDERSTAND AND AGREE TO THE ABOVE CONDITIONS**

**Parent / Caregiver:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (full name)

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**