Parents' Authorisation for School to Administer Medication

Child's Full Name: _____ Class: _____

For more than one medication, please complete additional sections.

Name of Medication _____

To be administered: From (date): _____ until (date): _____

Dose to be given: _____ Time to be given: _____

Does the medication need to be stored in the fridge? Yes / No

Name of Medication _____

To be administered: From (date): _____ until (date): _____

Dose to be given: _____ Time to be given: _____

Does the medication need to be stored in the fridge? Yes / No

Name of Medication _____

To be administered: From (date): _____ until (date): _____

Dose to be given: _____ Time to be given: _____

Does the medication need to be stored in the fridge? Yes / No

Please note: *For medications such as paracetamol, ibuprofen and anti-histamines that need to be given to children over a period of time, we may contact parents to check whether they have had a dose prior to school. This will usually apply to situations where the medication is to be given before 12.30pm.*

Parent/Guardian signature: _____

Please print name: _____

Date: _____