Medicine Authority Form

ADD YOUR SCHOOL LOGO HERE

Student name:	
Class teacher:	
Room/Year:	
Family doctor:	
Prescribing doctor:	
Date:	

MEDICATION DETAILS	
Medical condition requiring medication (e.g. allergies):	
Name of medication:	
Medicine type (e.g. tablet, liquid):	
Dosage:	
Does the medicine need to be kept in the fridge?	*Circle*: YES / NO
Preferred time(s) for medicine to be given:	
Procedure for administering medicine (e.g. student can self-administer under supervision, adult required to administer, use the syringe provided, etc.):	
Start date:	End date:
Other (e.g. ongoing, take until finished):	
Additional info (e.g. side effects to look out for):	
Does the student have an individual plan for this condition?	*Circle*: YES / NO

Please read the following statements and sign below to indicate your agreement.

- 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.
- I assure the school that this is not the first time my child has been given this medicine (i.e. the first dose was given at home).
- I accept that the school may not have trained medical personnel to administer medications.
- I accept that the school cannot guarantee that the medication will be given at a precise time or by the same person.
- I will notify the school about any changes in dosage, time, or procedures by filling out a new Medicine Authority Form.
- I will deliver medication to the school, unless it is appropriate for the student to bring it with them. Supplied medication is in its original container/packaging labelled with the name of the student, instructions, and dose required. I understand that it is my responsibility to supply medicine needed when off site (e.g. trips, camps), if not already supplied.
- I will ensure that the medicine is not past its expiry date.
- I accept that medication that is no longer required is returned to parents/caregivers by the school.

Parent/Caregiver name:	
Signature:	**Date:**

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OFFICE USE ONLY				
Student has an individual plan:	*Circle*: YES / NO			

		Recorded in SMS		
	Date	**YES**	**NO**	**N/A**
Medication expiry:				
Replacement medication requested:				
Replacement medication expiry:				
Replacement medication requested:				
Replacement medication expiry:				
Replacement medication requested:				
Replacement medication expiry:				