Medicine Authority Form

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

Date:

MEDICATION DETAILS	
Medical condition requiring medication:	
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:	
Start date:	End date:
Other: (e.g. ongoing, take until finished)	
Additional info: (e.g. side effects to look out for)	
Does the student also have a health plan for this condition?	*Circle*: **YES / NO**

PROCEDURE FOR GIVING MEDICINE
(e.g. student can self-administer under supervision, adult required to administer, use the syringe provided etc.)

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 the medication personally to school in its original packaging.
- I will ensure that the medicine is not past its expiry date.
- I accept that the school will dispose of any uncollected medicine at the end of the year.
- I understand that it is my responsibility to supply medicine needed when off site (e.g. trips, camps).

Parent/Caregiver name:	
Signature:	Date:

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OFFICE USE ONLY

Student has health plan:	*Circle*: **YES / NO**

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

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