LEARN TO LOVE
LOVE TO LEARN
St Monica's
PRIMARY SCHOOL WODONGA

AUTHORISATION TO ADMINISTER MEDICATION

I, _____ ***(parent/guardian name)*** authorise a member of St. Monica's Primary School staff to administer the following medication to my child:

CHILD'S NAME: _____

CHILD'S CLASS: _____

NAME OF MEDICATION: _____

AMOUNT TO BE ADMINISTERED: _____

TIME TO BE ADMINISTERED: _____

DAY & DATE TO BE ADMINISTERED: _____

COMMENTS: _____

_____

_____

_____

_____
Parent/Guardian Name

_____
Parent/Guardian Signature

Date: _____

*** Please note that all medication held at the school is to be kept in its original packaging with the child's name and required dosage clearly marked on the box/bottle.**
**** Analgesics (Panadol/Nurofen/ Asprin etc cannot be administered to children by staff at school.)**

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