AUTHORISATION TO ADMINISTER MEDICATION

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

Student's Name: _____

Student's Class: _____

Name of Medication: _____

Amount to be Administered: _____

Time to be Administered: _____

Day/Date to be Administered: _____

Comments _____

_____

Parent/Guardian Signature: _____

Date : _____/_____/_____

NB. All medications held for students at school are to be kept in their original packaging, with the student's name and required dosage clearly marked on the box/bottle by way of a pharmacist label;

Analgesics (Panadol/Nurofen/Asprin, etc) cannot be administered by staff at School unless approved by a Doctor, provided directly by parents, and a signed Authorisation to Administer Medication form is held.

OFFICE USE ONLY

Medical box/pack created ☐
Pharmacist label ☐
Expiry checked ☐
Medication recorded on google doc ☐
Plan updated on Simon if applicable ☐

Actioned by _____ **Date** _____