Medication Authority Form

I give permission for the following medication (one medication per form) to be administered to my child as outlined below. I will notify the College in writing if the order changes.

: _____

: _____

Home Group: _____

Medication: _____

Dose: _____

Route *(oral, topical, eye drops)*: _____

Time *(e.g. lunch time, 4 hourly)*: _____

Cease medication on *(if applicable)*: _____

RECORD OF ADMINISTRATION (*STAFF USE ONLY*)

Student's Name:…….. Student Code:…….. Date of Birth: ……..

Please complete this form when administrating medications

RECORD OF TIME GIVEN (For School Use Only)												
					Tick when checked							
Date	Time	Medication	Reason (symptoms, or scheduled)	Dose	Correct Child	Correct Medication	Correct Dose	Correct Route (eg: oral, topical, inhaled)	Number of tablets/capsules remaining (must be completed for Schedule 8 medications)	Staff member administering (print name and initial)	Staff member checking* (print name and initial)
EXAMPLE			*e.g.: Headache, or scheduled medication*	*2 tablets, 50mgs*	√	√	√	√	*e.g. 18*		