DOREEN PRIMARY SCHOOL

Medication Authority Form
for a student who requires medication whilst at school

Student’s Name: ___________________________ Grade ______________________

<table>
<thead>
<tr>
<th>Medication required:</th>
<th>Dosage (amount)</th>
<th>Time/s to be taken</th>
<th>Instructions</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Please indicate if there are specific storage instructions for the medication:

__________________________________________________________________________
__________________________________________________________________________

Medication delivered to the school

Please ensure that medication delivered to the school:

☐ Is in its original package

☐ The pharmacy label matches the information included in this form.

Authorisation:

Name of Parent/Carer
Signature: ___________________________ Date: ___________________________

If additional advice is required, please attach it to this form.

Parent/Carer to complete

Student Name: ___________________________ Name of Medication: ___________________________ Time/s to be taken: ___________________________
**DOREEN PRIMARY SCHOOL**

**Medication Authority Form**
for a student who requires medication whilst at school

Student’s Name: ___________________________ Grade ___________________________

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<tr>
<th>Name of Medication/s</th>
<th>Dosage (amount)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Start date: / /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>End Date: / /</td>
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<tr>
<td></td>
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<td></td>
<td>□ Ongoing medication</td>
</tr>
</tbody>
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Please indicate if there are specific storage instructions for the medication:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**Medication delivered to the school**

Please ensure that medication delivered to the school:

☐ Is in its original package

☐ The pharmacy label matches the information included in this form.

**Authorisation:**

Name of Parent/Carer

Signature: ___________________________ Date: ___________________________

If additional advice is required, please attach it to this form

**Parent/Carer to complete**

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<th>Name of Medication:</th>
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