

DOREEN PRIMARY SCHOOL

Medication Authority Form

for a student who requires medication whilst at school

Student's Name: _____ Grade _____

Medication required:

Name of Medication/s	Dosage (amount)	Time/s to be taken	Instructions	Dates
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing medication

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.

<u>Authorisation:</u>	
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
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