AUTHORISATION TO ADMINISTER MEDICINES

CHILD'S NAME:		
YEAR: (please circle)	R / 1 / 2 / 3 / 4 / 5 / 6	
DATE MEDICINE FIRST TAKEN:		
MEDICINE EXPIRY DATE:		
I confirm that the medicine is in its original packaging, that it was prescribed by a doctor and clearly shows the prescription label		Please Sign/Initial
I understand that an **ADULT** must hand in and collect the medicine each day		
I understand that if the medicine is to be retained in school, it is my responsibility to ensure an adequate supply is maintained.		

NAME OF MEDICINE		
DOSAGE REQUIRED (only 1 dose per day can be given for antibiotics)		
TIME(S) MEDICINE TO BE ADMINISTERED: 10.45 am (1 hr before food)/1 pm (1 hr after food)		
START DATE: END DATE:	/ / / /	
MEDICAL CONDITION (must be completed)/ FURTHER INSTRUCTIONS		
I understand that school staff will follow the instructions I have given above. It is my responsibility to advise school of any alterations to dosage or times of administration and to ensure that the medication is within date.		Please Sign/Initial

Signed/Date by Parent/Guardian: ______________________

Received/Checked by staff member: ______________________