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 <u>its original packaging</u>, that it was <u>prescribed by a doctor</u> 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		
TIME(S) MEDICINE TO BE ADMINISTERED:		
START DATE: END DATE:	/ / / /	
MEDICAL CONDITION/ FURTHER INSTRUCTIONS		
I understand that school staff will follow the instructions I have given above. It is my responsibility to advise school of any alternations to dosage or times of administration and to ensure that the medication is within date.		**Please Sign/Initial**

Signed by Parent/Guardian: _____

Received/Checked by staff member: _____