PARKHILL PRIMARY SCHOOL

MEDICAL AUTHORITY FORM

The following form must be completed by the parent/guardian

Details of medication to be administered

Student name ____ **Grade** _______________________

Reason for Medication ____

Medication ____

Dosage ______________________________**Time to be administered**________________________

Medication will need to be administered until : Date_______/______/________________

☐ *Medication **must** be in original package (please check and tick)*

☐ *The pharmacy label **must** match the information provided. (please check and tick)*

☐ *Additional Information: see reverse side of form (please tick if additional Information supplied)*

I ____ (parent/guardian) hereby authorise the staff of Parkhill Primary School to administer medication to my child as per details provided above.

Signature: ____ **Date:** _______/______/________________

Office use:
Medication is stored:

☐ Cabinet ☐ Refrigerator ☐ with Staff / Student

Date	Medication	Dosage	Time Administered	Administered by: Name	Signature

PARENTS PLEASE REMEMBER TO COLLECT UNUSED MEDICATION AT THE END OF YOUR CHILD'S TREATMENT.

Date	Medication	Dosage	Time Administered	Administered by	Signature