Medication Authorisation Form

Child's Name:_____ School: _____

All medication needs to be, in the original container, clearly marked with the child's name and dosage as per prescribed medication.

Over the counter medication must be accompanied by authorisation from a Medical Practitioner with the above mentioned criteria outlined including a date range that the medication is relevant for.

Parents/guardians to fill out this section:

Date:		
Is the medication in the child's name	Yes / No	
Type of medication		
Dosage required		
Time to be administered:		
Signature of parent /guardian		Date:
To be administered	Every day this week ☐	Every day this term ☐

Please Note: Parent will be required to sign the right hand column of the table below on the collection of the child.

Staff to fill out this section:

DATE	Is the medication in the child's name?	The medication is the same as stated by the parent/guardian?	Expiry Date	Is expiry date still valid?	Time administered	Staff & 2nd Staff to sign as witness	Date & Time	Parent Initial
/ /	Y / N	Y / N	/ /	Y / N		1. 2.	1. 2.	

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