Craigieburn Primary School

Medication Authority Form

PARENT/GUARDIAN DETAILS

Name: _____

I hereby authorise the staff of Craigieburn Primary School to administer medication to my child as detailed below.

Signature: _____ Date: _____

CHILD'S DETAILS

Name:_____ Grade: _____ Room: _____

Name of Medication: _____

Reason for Medication: _____

Type of Medication: (Please Tick) ☐ Tablet ☐ Capsule ☐ Elixer ☐ Drops

☐ Puffer ☐ Cream ☐ Syrup ☐ Other: _____

Dosage: Amount to be given: _____

Frequency: ☐ 10.50 am

☐ 1.15 pm

Duration: ☐ This medication is for today only (date: _____)

☐ This medication is ongoing from _____ to _____

Notes: _____

_____

OFFICE USE ONLY:

Entered on Announcement Sheet ☐

Medication kept on hand to be used as required for a Medical Condition ☐