



Medication Authority Form

I give permission for the following medication (one medication per form) to be administered to my child as outlined below. I will notify the College in writing if the order changes.

_____ :

_____ :

Home Group: _____

Medication: _____

Dose: _____

Route (*oral, topical, eye drops*): _____

Time (*e.g. lunch time, 4 hourly*): _____

Cease medication on (*if applicable*): _____

A handwritten signature in cursive script, appearing to read "Pamela", is written over a vertical barcode.

RECORD OF ADMINISTRATION (STAFF USE ONLY)

Students Name:	Student Code:	Date of Birth:
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Please complete this form when administering medications

RECORD OF TIME GIVEN (For School Use Only)											
Date	Time	Medication	Reason (symptoms, or scheduled)	Dose	Tick when checked				Number of tablets/capsules remaining (must be completed for Schedule 8 medications)	Staff member administering (print name and initial)	Staff member checking* (print name and initial)
					Correct Child	Correct Medication	Correct Dose	Correct Route (eg. oral, topical, inhaled)			
<i>EXAMPLE</i>			<i>e.g.: Headache, or scheduled medication</i>	<i>2 tablets, 50mgs</i>					<i>e.g. 18</i>		