Medicine Authority Form

Date: _____

Child's Name: _____

Class Teacher: _____ Room/ Level: _____

I/we request that (child's name) _____ be given

(dose and name of medicine) _____

At (time/s) _____

Condition for which medicine is given: _____

Name of prescribing doctor: _____

I/we accept responsibility for:

- the decision to give this medication to my/our child, and acknowledge that the school is in no way responsible for that decision, now or in the future.
- notifying the school about any changes in dosage, time, or procedures, by filling out a new Medicine Authority form.
- delivering the medication personally to school.
- Ensuring that the medicine is not past its "use by" date.

I/we accept that the school:

- may not have a trained medical officer to administer medications.
- cannot guarantee that medication will be given at a precise time or by the same person.
- will dispose of any uncollected medicine at the end of the year.

Signed: _____ (parent or guardian)

Date: