

Medication Authority Form



Student's Name: _____

Allergies: _____

Name of Medication:
Prescribed Dosage:
Time(s) to be given:

RECORD OF ADMINISTRATION: (To be completed by person giving medication)

Date <small>(dd/mm/yyyy)</small>	Time	Dose given	Tick when checked (✓)					Name of staff <small>(Please print and initial)</small>	
			Right time	Right child	Right dose	Right route <small>(oral/inhaled)</small>	Right medication		

I/We the parents/guardians give authority to Casey Grammar School to administer my child's medication as per the above instructions.
 By signing this form, I agree with and have adhered to all requirements as per the Student Medication Policy.

Print Name: _____

Signed: _____

Date _____