Medication Authority Form

Student's Name: _____ Allergies: _____

Name of Medication:
Prescribed Dosage and Time to be administered:
Include dates if multiple does are required:

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

Date (dd/mm/yyyy)	Time	Dose given	Tick when checked (√)					Name of staff *(Please print and initial)*	
			Right time	Right child	Right dose	Right route (oral/inhaled)	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_____