PARKHILL PRIMARY SCHOOL

MEDICAL AUTHORITY FORM

The following form must be completed by the parent/guardian

Details of medication to be administered

Date ……..……

Student name ……..……..…… **Grade** ……..……..

Reason for Medication ……..……..……..…..……..…..

Medication ……..……..……..…..

Dosage ……..……..……..……

Time to be administered ……

Medication will need to be administered until : Date …….

☐ *Medication **must** be in original package (please check and tick)*

☐ *The pharmacy label **must** match the information provided. (please check and tick)*

☐ *Additional Information: see reverse side of form (please tick if additional Information supplied)*

I …… (parent/guardian) hereby authorize the staff of Parkhill Primary School to administer medication to my child as per details provided above.

Signature:……..Date:……

Office use:

Medication is stored: ☐ Cabinet ☐ Refrigerator

Date	Medication	Dosage	Time Administered	Administered by: Name	Signature
					.

PARENTS PLEASE REMEMBER TO COLLECT UNUSED MEDICATION AT THE END OF YOUR CHILD'S TREATMENT.