SHORT TERM/INFREQUENT MEDICATION FORM
(EG, ANTIBIOTICS)

(This form is valid for 14 days only from the date this authorisation is given)

I authorise the Teacher, Nurse or Office Staff in charge to administer the following medication to my child:

STUDENT’S NAME: .................................................................................................................. GRADE: .................

MEDICATION: ..........................................................................................................................

All medications must be in original packaging and within the expiry date. If medication is prescribed by a doctor the label must be clearly displayed and intact. If medication has been purchased over-the-counter it must have the child's name labelled clearly.

DOSAGE: ..................................................................................................................................

DATES TO BE GIVEN MEDICATION: ..........................................................................................

TIMES TO BE GIVEN MEDICATION: ..........................................................................................

Signed: ................................................................. (Parent/Guardian) Dated: ...../ ...../ ..... Yes / No

Can your child collect this medication on your behalf at the end of the school day

RECORD OF TIME GIVEN (For school use only)

IF TABLETS, HOW MANY SUPPLIED: .........................................................................................

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Medication collected by: ................................................................. Dated: .................................