THOMAS MITCHELL PRIMARY SCHOOL
MEDICATION AUTHORISATION FORM

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: ……/……/……

Can your child collect this medication on your behalf at the end of the school day Yes / No

RECORD OF TIME GIVEN (For school use only)

IF TABLETS, HOW MANY SUPPLIED: ……

Date	Time	Signature	Balance Tablets	Date	Time	Signature	Balance Tablets

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