Heathmont East Primary School

Medication Authority Form

CHILD'S DETAILS

Name:____ Grade: _________

Name of Medication: ____

Reason for Medication: ____

Type of Medication: (Please Tick) ☐ Tablet ☐ Capsule ☐ Elixer ☐ Drops

☐ Puffer ☐ Cream ☐ Syrup ☐ Other: ___________________

Dosage: Amount to be given: _______________________________________

Frequency: ☐ Every ____ hours (time of previous dose: ___________)

☐ Once a day at ___________ (time)

☐ As required

Duration: ☐ This medication is for today only (date: ____________________)

☐ This medication is ongoing from ____________ to _____________

Notes: ____

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**Please ensure all medication is in-date and in ORIGINAL packaging with all name and dosage details visible ie, not cut, ripped or worn.

PARENT/GUARDIAN DETAILS

Name: ____

I hereby authorise the staff of Heathmont East Primary School to administer medication to my child as detailed blow.

Signature: ____________________________________ Date: ______________

Contact number: ____