**Authorisation for School Staff to Administer**

**Medication to Students**

(\* this form is to accompany any medication brought into school)

Please administer the accompanying medication (as per directions) to my child:

……………………………………………..…………… **(Child’s Name)** …………….………………….. **(Class ie. JP)**

Name of medication …………………………………………………………………………………………………………………………

Diagnosed medical condition *(optional) ……………………………………………………………………………………………*

Special instructions *(if any)* ……………………………………………………………………………………...………………………

………………………………………………………………………………………………………………………………………………………….

Checklist (all boxes must be ticked before medication will be administered)

*(please tick)*

□ Medication has been prescribed by a doctor and has a pharmacy label attached

 - or -

□ Medication was purchased ‘over the counter’ without a prescription

□ Medication is in its original container

□ Clear instructions for administering/dosage, etc. are with medication

□ My child has had this medication before (this is not the first dose administered)

□ Medication is within the expiry date

Name (parent/caregiver) ……………………………………………………………

Signed (parent/caregiver) ……………………………………………………………

Date / /