AUTHORISATION TO ADMINISTER MEDICINE

Parent's Name ____

Name of staff who will administer
the medicine ____

Administering medicine to, Child's Name ________________________________

Class ________________

Please provide the following vital information and attach to the medicine:

Name of medicine	
How many times per day should medicine be given to child?	
What time/s each day should medicine be given?	
What amount per dosage?	
Should medicine be refrigerated?	YES/NO
Will the medicine be collected at the end of each day	YES/NO

I authorise the above named to administer medicine as detailed above

Parent's signature _____________________________ Date __________________

School Use:

Given by	*Amount*	*At*	*Date*

AUTHORISATION TO ADMINISTER MEDICINE Continuation

School Use:

Given by	*Amount*	*At*	*Date*