



# THOMAS MITCHELL PRIMARY SCHOOL MEDICATION AUTHORISATION FORM

*(This form is valid for the current school year only)*

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

**STUDENT'S NAME:** ..... **GRADE:** .....

**MEDICAL CONDITION:** .....

**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:** .....

**FREQUENCY OF DOSAGE::** .....

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

Signed: ..... (Parent/Guardian) Dated: ...../...../.....

### 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: .....

