THOMAS MITCHELL PRIMARY SCHOOL
MEDICATION AUTHORISATION FORM

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

I authorise the school nurse, office staff or teacher 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.

EXPIRATION DATE CHECKED ……/……../…….

IF TABLETS, HOW MANY SUPPLIED:……

Total tablets received verified by receiving staff member…… Initial ……..

DOSAGE:……

FREQUENCY OF DOSAGE:……..

TIMES TO BE GIVEN MEDICATION: ……

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

RECORD OF TIME GIVEN (For school use only)

Date	Time	Signature	Balance Tablets	Date	Time	Signature	Balance Tablets

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

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(Continuation Page)

Date	Time	Signature	Balance Tablets	Date	Time	Signature	Balance Tablets

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