Craigieburn Primary School
Medication Authority Form

PARENT/GUARDIAN DETAILS

Name: ________________________________

I hereby authorise the staff of Craigieburn Primary School to administer medication to my child as detailed below.

Signature: __________________________ Date: ________________

CHILD’S DETAILS

Name: ________________________________ Grade: _________ Room: _________

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: □ 10.50 am □ 1.15 pm

Duration: □ This medication is for today only (date: _________________)
          □ This medication is ongoing from ______________ to ______________

Notes:  __________________________________________________________________________
          __________________________________________________________________________

OFFICE USE ONLY:

Entered on Announcement Sheet □

Medication kept on hand to be used as required for a Medical Condition □