Chirnside Park Primary School

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Medication Authority Form

PARENT/GUARDIAN DETAILS

Name:_____

I hereby authorise the staff of Chirnside Park Primary School to administer medication (to be supplied by the parent) 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 ☐ Elixir ☐ Spray

☐ Drops ☐ Puffer ☐ Cream ☐ Other: _____

Dosage: *Amount to be given:* _____

Frequency:

☐ At 12.00 noon (Medication Bell)

☐ At 1.00pm (With Lunch)

☐ Every ____hours *(time of previous dose: _____)*

☐ Once a day at _____ *(time)*

☐ As required

Duration:

This medication is for today only (*date:* _____)

This medication is ongoing from _____ to _____