Permission for the Administration of Medication

BEFORE MEDICATION IS ADMINISTERED BY SCHOOL STAFF THE FOLLOWING MUST BE COMPLETED:

1. This permission form
2. Medication must be clearly labelled stating:
   ◦ name of child
   ◦ dosage and times of administration

Please ask your pharmacist for this information when medication is issued.
Please note: Analgesics, cough mixtures etc, will not be administered unless written permission is given by a parent or guardian.

PARENT/GUARDIAN AUTHORITY FORM
Permission Form valid for one week only, unless there is a permanent medication with special negotiation.

I hereby authorise medication to be administered to my child.

CHILD’S NAME: _________________________
______________________________

MEDICAL PROBLEM: __________________________________________________________

MEDICATION: _________________________ DOSAGE: _________________________

TIMES FOR ADMINISTRATION: ________________________________________________

DATES TO BE ADMINISTERED AT SCHOOL: _______________________________________

SIGNATURE OF PARENT/GUARDIAN ______________________ DATE: ________________

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Principal’s/F.A.P. Signature: ________________________________

Note the name of the parent/guardian who requested the medication administration.

Name: ________________________________ relationship to child _______________________

Contact Number: ________________________ Unused medication returned to parent: Yes  No