St Patrick's Parish Primary School

Permission for the Administration of Medication

Appendix 1

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: _____

DOSAGE	DATE	TIME	

Principal or delegate 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