



## Medication Authority Form

I give permission for the following medication (one medication per form) to be administered to my child as outlined below. I will notify the College in writing if the order changes.

\_\_\_\_\_ :

\_\_\_\_\_ :

**Home Group:** \_\_\_\_\_

**Medication:** \_\_\_\_\_

**Dose:** \_\_\_\_\_

**Route** (*oral, topical, eye drops*): \_\_\_\_\_

**Time** (*e.g. lunch time, 4 hourly*): \_\_\_\_\_

**Cease medication on** (*if applicable*): \_\_\_\_\_

A handwritten signature in cursive script, appearing to read "Pansel...". The signature is written in black ink on a white background.

# RECORD OF ADMINISTRATION (STAFF USE ONLY)

Students Name: .....	Student Code: .....	Date of Birth: .....
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Please complete this form when administering medications

RECORD OF TIME GIVEN (For School Use Only)											
Date	Time	Medication	Reason (symptoms, or scheduled)	Dose	Tick when checked				Number of tablets/capsules remaining (must be completed for Schedule 8 medications)	Staff member administering (print name and initial)	Staff member checking* (print name and initial)
					Correct Child	Correct Medication	Correct Dose	Correct Route (eg. oral, topical, inhaled)			
<i>EXAMPLE</i>			<i>e.g.: Headache, or scheduled medication</i>	<i>2 tablets, 50mgs</i>				<i>e.g. 18</i>			