AUTHORISATION FOR TEMPORARY MEDICATION

This form is to be completed whenever a temporary medication is introduced (eg. Antibiotics, paracetamol, antihistamine etc.). Teachers will not be able administer medication unless this form has been completed, signed and the original medication packaging or copy of the pharmacy label is produced.

STUDENT: _____ NAME OF TEACHER:_____

Does the student currently receive medication at school?	**YES/NO (cross out non applicable)**
What is the temporary medication to be administered?	
What are the dosage details of the temporary medication?	
What date is the temporary medication to commence?	
What date is the temporary medication to cease?	

PARENTS SIGNATURE:_____ DATE: _____

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