St Joseph's Primary Bombala
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SHORT TERM/ INFREQUENT MEDICATION AUTHORISATION FORM

Eg Antibiotics/Panadol

Dear Parent/Guardians

In order to provide the safest possible administration of your child's medication during school hours, we ask you to complete this form. To ensure no error is made in tablet identification or dosage, we ask that you send your child's medication to the school in the correctly labelled bottle supplied by the chemist.

Medication is stored in a central secured location and administered from that room by a staff member. Medication cannot be put into school bags and lunch boxes, etc.

I authorise the teacher/staff member to administer the following medication to my child:

Childs Name:______________________________ Date:______________________________

Childs Teacher:___________________________________ Class:______________________

Dates Medication is to be administered____

Name of Medication:_______________________________ Medication Expiry:____________

The type of dose to be administered. eg. mls/puffs/tablets____________________________

Time/s Medication to be administered:____

Parent/Guardian Name:____

Signature of Parent/Guardian:____

Parent/ Guardian Contact number:____

Please note:

Where medication is required to be administered three times a day, we request (where possible and suitable) this be administered at home at breakfast time, immediately after school and in the evening.