Donburn Primary School

Medication Authority Form 2021

Last Name:	**First Name:**
Year Level:	**D.O.B:** **Approximate Weight** *(optional):*
Brand Name of Medication: (1 medication per form) **Generic Name of Medication:** **Storage:** ☐ Room temperature ☐ Fridge	**Dose:** **Frequency:** **Expiry Date:**
Reason *(please tick)*: ☐ Pain relief ☐ Antibiotic ☐ Allergy relief ☐ Asthma ☐ Other (details):	**If your child requires their Medication, do you wish to be informed** *(please tick)*: ☐ No ☐ Yes, via phone call ☐ Yes via First aid Notification Form

Please ensure medication supply includes:

- The medication is in its original packaging.
- A labelled measuring cup, syringe or spoon is provided if appropriate.
- The medication is clearly labelled with the child's name and date of birth above.
- The recommended dosage required for the child above is clearly displayed.
- The medication is within expiry date and expiry date clearly visible.

I _____ (Parent /Guardian NAME) consent to the above medication to be administered to my child (named above) at the stated times above.

_____ (Parent / Guardian signature) **Date:** ____ / ____ / ____

Office use only:

Medication	Dose	Date	Time	Right Child	Right Medication	Right Dose	Right Route	Staff 1	Witness