St Paul
Lutheran School

Administration of Medication Authority

STUDENT'S NAME _____ TEACHER _____

DATE OF BIRTH _____ YEAR/CLASS _____

The completion of this Authority is required to allow the school to responsibly undertake its duty of care to our students in the safe administration of medication to your child.

PLEASE NOTE: Medication must be in its original container, expiry date must be visible and if a prescription medication, dispensary label from the pharmacy must be attached.

NAME OF MEDICATION _____EXPIRY DATE _____

TIME/S TO BE GIVEN _____DOSAGE _____(per dose) ROUTE _____ (eg. Oral, Inhalant)

REASON FOR MEDICATION ADMINISTRATION _____

DAILY: (please circle) YES NO AS REQUIRED

If NO/AS REQUIRED, please explain when: _____

ADMINISTRATION CONTINUES UNTIL _____/_____/_____

Name of Medical Practitioner:_____ Phone:_____

Medical Practitioner Signature_____ Date_____

I request the administration of medication as detailed above for my child. I understand that a new administration of medication authority must be completed at the beginning of each new school year or if there are any changes to these instructions.

Parent/Guardian Name_____ Signature_____

Date_____

Medication will be sent home at the end of Term 4. It is your responsibility to return medication at the beginning of the new school year. Expired medication will be sent home via your child's class tray.

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