Medicine Authority Form

Student's name	
Class teacher	
Room	
Date:	
I request that my child be given the following medication	
Time(s) when medicine is given	
Procedure for giving medicine	
Condition for which medicine is given	
Name of prescribing doctor	

I accept responsibility for:

- the decision to give this medication to my child, and acknowledge that the school is in no way responsible for that decision, now or in the future
- notifying the school about any changes in dosage, time, or procedures, by filling out a new *Medicine Authority form*
- delivering the medication personally to school
- ensuring that the medicine is not past its expiry date.

I accept that the school:

- may not have a trained medical officer to administer medications
- cannot guarantee that medication will be given at a precise time or by the same person
- will dispose of any uncollected medicine at the end of the year.

Parent/guardian's name	
Signature	
Date	