Lysterfield Primary School

Medication Authority Form

PARENT/GUARDIAN DETAILS

Parent/Guardian's name:_________________________________

I hereby authorise the staff of Lysterfield Primary School to administer medication to my child as detailed below

Signature: ____________________________ Date: ____________

CHILD'S DETAILS

Name:________________________ Grade:______

Name of Medication: ____________________________

Reason for Medication: ____________________________________

____

Type of Medication: *(please tick)* ☐ Tablet ☐ Capsule ☐ Elixir ☐ Spray

☐ Drops ☐ Puffer ☐ Cream ☐ Other: ____________________

Dosage: *Amount to be given:* ___________ ***(time of previous dose: _________)***

Frequency:
- ☐ At 12.00 noon
- ☐ At 1.00pm (With Lunch)
- ☐ Every ____hours
- ☐ Once a day at ____________ *(time)*
- ☐ Other ___________________

Duration:
- ☐ This medication is for today only (*date:* ___________)
- ☐ This medication is ongoing from __________ to ___________