Elliminyt
Primary School

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CONFIDENTIAL

Authority for staff to dispense medication during school hours

Name of Student: ……..… Year Level: ……

Exact name of medication to be housed and/or administered.	
Medical condition/reason for the medication.	
The exact dosage to be administered.	
The time for the medication to be administered.	
Dates for the administering of medication.	From …… To …… inclusive.
Name(s) of doctor(s) who has/have prescribed this medication.	Name/s ……... Phone No……

- All medication is administered by authorised personnel wherever possible.
- **All medication (tablets or mixtures) must be clearly marked with child's name and grade and time/dosage required.**
- It is the responsibility of the parent to **personally** deliver the medication to the school (in a dosette where applicable).
- I acknowledge that in event of an emergency arising from taking this medication, an ambulance may be called at parents' expense.

I give approval for the above listed medication to be administered to my child at school according to the stated details. A parent or guardian will deliver the medication to the main office/classroom as required.

Signed: …… (parent/guardian)

Name: …… (parent/guardian)

Date: ……

Approved by the Principal: ……

Date:……