ST PETER'S PRIMARY SCHOOL

AUTHORISATION TO ADMINISTER MEDICATION

This form is to be completed when staff are required to administer prescribed medication to a student during school hours.

Student's prescribed medication is to be provided to the front office in the original container, if possible, clearly showing the name of the student, the name of the medication, the dosage and frequency.

If another container needs to be used (ie, half dosage tablets), please provide the office with a copy of the original label.

(Medication for students in Pre Kindy, Kindy and Pre Primary will be stored in the Early Childhood Area.)

Student's Full Name _____ Class _____

I request that a staff member of St Peter's School administer/supervise self-administration of the following medication as prescribed by

Dr _____ for the purpose of treating _____

Name of medication _____

(Quantity of medication given to School _____ mls/pills)

Dosage to be given _____ Time to be taken _____

Comments _____

_____

Full Name of Parent _____

Signature _____ Date ___/___/___