AUTHORISATION FOR TEMPORARY MEDICATION

This form is to be completed whenever a temporary medication is introduced (e.g. antibiotics, paracetamol, antihistamine etc.). Staff will not be able to administer medication unless this form has been completed, signed and the original medication packaging with a pharmacy label on it is produced.

STUDENT: _____ DATE OF BIRTH:_____ Room: _____

PARENTS SIGNATURE:_____ **DATE:** _____

Does the student currently receive medication at school?	YES / NO (cross out non applicable)
What is the temporary medication to be administered?	
What are the dosage details of the temporary medication?	
What date is the temporary medication to commence?	
What date is the temporary medication to cease?	

OFFICE USE: ☐ Pharmacy Label Present ☐ Staff in Classroom Notified

Medication given:

Time: _____ am/pm Given By: _____ Initial: _____ Collection Witness: _____ Initial: _____
Time: _____ am/pm Given By: _____ Initial: _____ Collection Witness: _____ Initial: _____
Time:_____ am/pm Given By:_____ Initial: _____ Collection Witness:_____ Initial: _____
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