



MEDICATION ADMINISTRATION AND TREATMENT AUTHORITY

STUDENT NAME: _____

DATE: _____

SECTION A - Medication required during school hours:

Time	Medication Name	Dosage	Type e.g. tablet/liquid

Medication prescribed by a medical practitioner **MUST** have a pharmacy label attached.

All medication **MUST** have the following details clearly labelled on the box/bottle:

- Student's name
- Name of the medication
- Dosage amount to be given
- Time the medication is to be administered.

SECTION B - Medication taken at home:

This information is very important if your child ever requires an ambulance to be called at school.

Time	Medication Name	Dosage	Type e.g. tablet/liquid

Please list medication below - **if "nil" please write "nil"**.

PARENT/CARER AUTHORITY

Parent/Carer Name: _____

Parent/Carer Signature: _____

Date: _____