Lysterfield Primary School

Medication Authority Form

for a student who requires medication whilst at school

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. **I understand the Medication needs to be in it's original packaging and the Pharmacy label needs to match the information detailed below.**

Contact number during school hours: ___________________________________

Signature: Date:

CHILD'S DETAILS

Name:____ Grade:___________

Name of Medication: ____

Reason for Medication: ____

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

Drops Puffer Cream Other: ______________________________

Dosage: Amount to be given: _________________ **Time last dose was given:** _______________

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 ____________

Medication pickup: ☐ I will pick this medication up from the office after school

☐ Please send this medication home with my child after school

Storage: (Please indicate if there are specific storage instructions for this medication)

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