## CHIRNSIDE PARK PRIMARY

### MEDICATION AUTHORITY FORM

#### PARENT/GUARDIAN DETAILS

Name: ________________________________

I hereby authorise the staff of Chirnside Park Primary School to administer medication (to be supplied by the parent) to my child as detailed below.

Signature: ___________________________ Date: __________________

#### CHILD’S DETAILS

Name: _____________________________ Grade: _____ Room: ____

Name of Medication: __________________________________________

Reason for Medication: _________________________________________

Type of Medication: (please tick)  
- [ ] Tablet  
- [ ] Capsule  
- [ ] Elixir  
- [ ] Spray  
- [ ] Drops  
- [ ] Puffer  
- [ ] Cream  
- [ ] Other: __________________________

Dosage: Amount to be given: __________________

Frequency:  
- [ ] At 12.00 noon (Medication Bell)  
- [ ] At 1.00pm (With Lunch)  
- [ ] Every ___ hours (time of previous dose: __________)
- [ ] Once a day at ____________ (time)
- [ ] As required

Duration:  
- [ ] This medication is for today only (date: ____________)
- [ ] This medication is ongoing from ___________ to ____________