AUTHORISATION TO ADMINISTER MEDICINE

AUTHORISATION

CHILDS NAME:.....

YEAR LEVEL:..... CLASSROOM TEACHER:.....

*As the parent/guardian of the above mentioned child I request and authorise Ilim College Nurse/Staff to administer the following medication.
*I warrant that the medication provided with this authority is that as described below.
*I am aware that any information regarding changes to this medication including type, dosage etc must be forwarded to Ilim College in writing.
*I am aware that it is my responsibility to maintain an adequate supply of this medication at Ilim College.

PARENT/GUARDIAN NAME:.....

PARENT SIGNATURE:..... DATE:.....

ADMINISTRATION INFORMATION

Name of Medication:.....

Quantity on Handover (Tablets/ML):.....Expiry Date:.....

Period for which Medication is to be administered: From:..... To:.....

Frequency of Dosage (ie Specific Times):.....

Medication Dosage:.....

Doctors Name:.....Phone:.....

Other Instructions *(ie: is it ongoing)*:.....

Name of Dispensing Staff:.....

OFFICE USE ONLY

The medication supplied with this authorisation is:

☐ a prescribed medication &

☐ in original package with pharmacist's label which states the childs name, dosage, frequency of administration, date of dispensing and expiry date