ST MARK'S SCHOOL MEDICATION AUTHORITY

Child's Name ……..…….... Child's DOB ……..……Class…….……..

I, as the parent or legal guardian, request and authorise the following medication to be administered to my son/ daughter.

Medication	
When to be given (please indicate specific time)	
Dosage	
Commencement date	
Conclusion date	

All medication is to be in a container labelled by a pharmacist, showing the name of the medication, the "use by" date, the name of the student's medical practitioner, the name of the student, the dosage and the frequency of administration.

It is the responsibility of the parent or person with the legal responsibility for the student to ensure that the medication:

a. is clearly labelled;
b. is not out of date;
c. is provided in sufficient quantities for the student's needs;
d. is collected from the school at the completion of the student's treatment.

Note:
A new **Student Medication Authority** must be completed:

1. If the dose or type of medication is altered;
2. If the regime is re-started following the conclusion date of the instructions from the medical practitioner above;
3. At the beginning of each new calendar year.

Signed: _____ Date _____
(Parent or person with legal responsibility for the student)

Parent's Name _____ Tel No:_____