

BELMONT PRIMARY SCHOOL
ADMINISTRATION OF MEDICATION
AUTHORISATION FORM

Dear Head Teacher

My child has been prescribed medication from our Doctor. For it to be effective it must be administered during the school day. Will you please make suitable arrangements for this to happen. My child has had this medication before and has not suffered any adverse effects from it. I understand that it is my child's responsibility to go to the office and ask for the medication.

Date

Name of child Class Teacher

Age Date of Birth

Address

The medication is

The medication should be taken at (time)

The previous dose was given at (time)

Reason for medication

Dosage Expiry Date.....

This treatment will end on

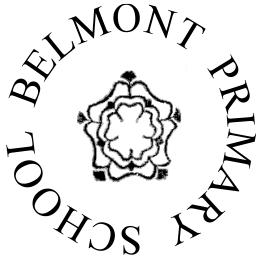
Note: Medicines must be in the original container as dispensed by the pharmacy.

I give my consent for you or one of your staff to administer it.

NAME OF PARENT

DISCLAIMER

Whilst we agree to give prescription medicine we accept no responsibility for any adverse reaction caused by giving the medication.



**CONFIRMATION OF THE HEAD'S AGREEMENT TO ADMINISTER
MEDICINE**

Date

Name of Child Class

Age Date of Birth

The medication is Dosage

The medication should be taken at (time)

The previous dose was given at (time)

Reason for medication

Expiry date This treatment will end on

I give consent for you or one of your staff to administer the above medication. My child has had this medication before and has not suffered any adverse effects from it.

NAME OF PARENT

DISCLAIMER

Whilst we agree to give medication we accept no responsibility for any adverse reaction caused by giving the medication.