Learning Together Every Day

Hammond Park

PRIMARY SCHOOL

AUTHORISATION TO ADMINISTER MEDICATION

This document applies to the short term administering of medication only. Refer to Medication Authority for long term medication.

STUDENT DETAILS

Surname:…… First Name:…….……

Year Grade: ……. Class Teacher: …….…….

Medical Condition: …….…….……...

Name of Medication: ……..……

Dosage: …….. Time(s) to be given: ……...……..

Date Commenced: …….. Date to Finish:……..

Signature of Parent/Guardian/Caregiver (please circle):……

Signature of Deputy Principal: …… Date: …….

DATE	DOSE GIVEN	TIME GIVEN	SIGNATURE (STAFF)