AUTHORISATION TO ADMINISTER MEDICATION

CHILDS NAME:	**DATE OF BIRTH:**
CLASSROOM TEACHER:	**YEAR LEVEL:**

MEDICATION ADMINISTRATION INFORMATION						
Name of medication/s Please ensure the medication delivered to school is in its original packaging and the pharmacy label matches the information on this form.	**Dosage *Quantity *mis**	**Expiry Date**	**Time/s to be taken**	**How is it to be taken? *Topical *Orally *Inhale *Injectable**	**Dates**	**Time of the last dose administered**
					Start Date: **End Date:** **Ongoing Medication**	
					Start Date: **End Date:** **Ongoing Medication**	

MEDICATION STORAGE

Please indicate if there are specific storage instructions for the medication:

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MONITORING EFFECTS OF MEDICATION

Please note school staff DO NO MONITOR the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

Any new medication initial administered SHOULD BE MADE at home under supervision of a parent/guardian. Following treatment can be made by the school staff upon written consent.

PARENT/GUARDIAN'S CONSENT

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

Parent/Guardian Name: _____

Parent Signature: _____Date: _____