



GOOD COUNSEL PRIMARY SCHOOL

Parent/Guardian's Authority Form

MEDICATION TO BE ADMINISTERED

This permission form is valid for one week only, unless there is permanent medication in which case special arrangements will need to be negotiated.

PERMISSION:

I hereby authorise medication to be administered to my child. Details are:

STUDENT'S NAME: YR LVL: CLASS:.....

MEDICATION:

TIME/S FOR ADMINISTRATION:

DOCTOR WHO PRESCRIBED MEDICATION:

PROBABLE PERIOD OF TREATMENT:

Signature of Parent/Guardian: Date:

PARENT/GUARDIAN DETAILS:

ADDRESS:

.....

PHONE/MOBILE NUMBER:



Good Counsel Primary School
Administration of Medication to Students
REGISTER

Archive in Student File - ADMIN

School: Good Counsel Primary School			
Student Name:			
Condition:			
Doctor:		Phone No.:	
Name of Medication:			
Pharmacist:		Phone No.:	
Method of Administering the Medication:			

DOSAGE	TIME	DATE	PERSON WHO ADMINISTERED MEDICATION
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Principal's Signature:.....
Mr Liam KENNY

Note the name of the Parent/Guardian who requested the medication administration.

Name:.....
(Please print)

Relationship:..... Contact No.:.....

Unused medication returned to parent: YES / NO

(Permission form is valid for one week only, unless there is permanent medication where special negotiation will take place).