

AUTHORISATION FOR ADMINISTRATION OF STUDENT MEDICATION

FORM A: Non-prescription medication – to be completed by Parent/Carer

Student Name: _____

School: _____

Year Level: _____

NON-PRESCRIBED medication to be given to student during school hours:

Name of medication	Expiry date	Dose	Route (mouth, nasal spray etc.)	Frequency or Time	Relation to meals or N/A	In original container?*	Student permitted to self-administer?
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No

I understand that this form provides authorisation for administration, or self-administration (if indicated) of **non-prescribed** medication to the student named. I understand that I should notify the school IMMEDIATELY if this information changes. *I understand that all medication **MUST** be supplied in the original container or Webster-pak, and that the school cannot administer medication if it is not supplied in the original container or Webster-pak.

Parent/Carer Name: _____

Relationship to student: _____

Address: _____

Phone number: _____

Signature: _____

Date: _____