The Charter School

STUDENT MEDICATION AUTHORISATION FORM

STUDENT'S NAME _____

MEDICAL CONDITION_____

Date of Birth _____

Parent/Carers Name and contact number_____

Details of medication to be administered

Name of Medication_____

Dose and Frequency_____

Date Dispensed_____ Expiry date_____

I hereby give the school authority to administer the prescribed drugs to the student named above, as requested and understand the drugs will be returned once they are out of date.

Signed_____

Print Name_____

Dated_____