



ROBERTS MCCUBBIN PRIMARY SCHOOL

# Medication Authority Form

## PARENT/GUARDIAN DETAILS

Name:.....

I hereby authorise the staff of Roberts McCubbin Primary School to administer medication to my child as detailed below

Signature:..... Date.....

## CHILD'S DETAILS

Name:..... Grade:.....

Name of Medication:.....

Reason for Medication:.....

DOSAGE: Amount to be given:.....

## FREQUENCY:

- At 1.30pm (with lunch)
- Every ..... hours (time of previous dose:.....)
- Once a day at .....(time)

## DURATION:

- This medication is for today only (date:.....)
- This medication is ongoing from.....to.....



ROBERTS MCCUBBIN PRIMARY SCHOOL

# Medication Authority Form

To be completed by the school.

Administered by:.....  
PRINT NAME

.....  
SIGNATURE

Date and Time:.....

To be completed by the school.

Administered by:.....  
PRINT NAME

.....  
SIGNATURE

Date and Time:.....

To be completed by the school.

Administered by:.....  
PRINT NAME

.....  
SIGNATURE

Date and Time:.....

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Administered by:.....  
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SIGNATURE

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