



Administration of Medication Authorisation Form A (Parent/Guardian)

Use this form to provide authorisation to the school to

- a.) administer **non-prescribed** medication to your child
- b.) administer **prescribed** medication to your child .(To authorise the school to allow your child to self-medicate, you must **also** arrange for a doctor, or the pharmacist dispensing the medication or a practice nurse from the prescribing doctor's surgery to complete the form "Administration of Prescribed Medication Authorisation Form B (Doctor/Pharmacist/Practice Nurse)
- c.) allow your child to self-administer their prescribed medication.

Student's Name	Surname or family name First given name Second given name
Medication to be given to student during school hours, as prescribed/authorised by the student's medical practitioner/pharmacist/practice nurse.	Name of medication Expiry date Dose and route (eg by mouth, by injection) Frequency Relation to meals or n/a Side effects, if any, school staff should be made aware of Medication has been supplied in original container with the instructions provided by the pharmacist. Yes/No Is the student permitted to self-administer this medication? Yes/No
Parent/Guardian's signature	Parent/Guardian name (please print) Address Signature: Date:

Important: Please notify school immediately of any changes to the details above.