Bimbadeen Heights Primary School

"Reaching for the Heights"

Medication Authority Form

Please use this form for all medicines that you supply to the office excluding Ventolin (please use the asthma_plan which covers permission to give asthma medications)

PARENT/GUARDIAN DETAILS

Name: _____ Phone number: _____

I hereby authorise the staff of Bimbadeen Heights Primary School to administer medication to my child as detailed below.

Signature: _____ Date: _____

CHILD'S DETAILS

Name: _____ Grade: _____

Name of Medication:

_____

Reason for Medication:

_____

Type of Medication (please tick): ☐ Tablet ☐ Capsule ☐ Elixir ☐ Spray ☐ Drops

Puffer ☐ Cream ☐ Other: _____

Dosage: _____ Time/s of Day: _____

Medication Expiry Date: _____ Refrigeration Required: Yes/No (Please Circle)

Duration: ☐ This medication is for today only (date :_____)

☐ This medication is ongoing from _____ to _____

This information collected will only be used for the purpose of administering medication as requested