AUTHORISATION TO ADMINISTER MEDICATION

CHILD'S FULL NAME……

AGE…… **YEAR LEVEL……**

HOME GROUP TEACHER NAME……

Period of time authorisation is to be valid

From……/……/…….. To……/……/……..

Condition for which medication is to be given

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Name of Medication and instructions for administration

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I understand that there is no registered medical officer employed at the College.

I hereby authorise Peace Lutheran College staff to administer the above mentioned medication to my child as set out above.

Date……

Signed……. Parent/Guardian's

Name (please print)