



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:

.....
.....

Name of Medication and instructions for administration:

.....
.....
.....

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

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

Note: All medications must be correctly labelled by a pharmacist.

Date.....

Signed..... (Parent/Caregiver)

Name (please print) (Parent/Caregiver)

Parent/Caregiver has collected unused medication that is no longer required to be administered at the College or instruction has been given for the nurse to return the unused medication to the pharmacy..... **Yes/No.**