

# SHORT TERM / INFREQUENT MEDICATION FORM

*eg. Antibiotics / Panadol*

I authorise the Teacher, Nurse or Education Support staff to administer the following medication to my child:

Student’s Name: …………………………………… ……. Grade: ……………………

Medication: ……………………………Route …………………. Dose: ……………..

Dates to be given: ………………………………………………………………………...

Times to be given: ……………………………………………………………………….

Signed: ………………………………………….. (Parent/Guardian)

Date: …………………………………………….

**RECORD OF TIME GIVEN (for school use only)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Date*** | ***Time*** | ***Signature*** |  | ***Date*** | ***Time*** | ***Signature*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |