MEDICATION AUTHORISATION

I, ____________________________________ [Parent/Guardian] hereby authorise a staff member of St Catherine of Siena School, Melton West, to administer the following medication to my child.

Child's Name	Class	Name of Medication	Dosage Required	Time to Administer

Please indicate [tick box below] how long the medication is to be administered:

❑ One Day Only

❑ Multiple Days - From [Date]: …………………………….. To [Date]: …………………………….

❑ When Required by Child or If Medication Has Not Been Administered at Home
- a Staff member is to ring me prior to confirm

Signed: __________________________________ **Date:** __________________________

MEDICATION AUTHORISATION

I, ____________________________________ [Parent/Guardian] hereby authorise a staff member of St Catherine of Siena School, Melton West, to administer the following medication to my child.

Child's Name	Class	Name of Medication	Dosage Required	Time to Administer

Please indicate [tick box below] how long the medication is to be administered:

❑ One Day Only

❑ Multiple Days - From [Date]: …………………………….. To [Date]: …………………………….

❑ When Required by Child or If Medication Has Not Been Administered at Home
- a Staff member is to ring me prior to confirm

Signed: __________________________________ **Date:** __________________________