

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	
	and the Property Mark the Control of the	1 11	and the state of the land of the land			
Plea	Se indicate [tick box below] now One Day Only	v long the i	medication is to be administered:			
	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					
Sigr	Signed: Date:					
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	
L						
Plea	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					
	- a Stair member is to ring m	e prior to c	COMMITT			