@ apollo **Apollo Parkways Primary School**

Medication Authority Form

PARENT/GUARDIAN DETAILS

Name:_____

I hereby authorise the staff of Apollo Parkways Primary School to administer medication to my child as detailed below.

Signature:_____Date:_____

CHILD'S DETAILS

Name:_____Grade:_____Room:_____

Name of medication:_____

Reason for medication:_____

Type of medication: (please tick) ☐ Tablet ☐ Capsule ☐ Elixer ☐ Drops

☐ Puffer ☐ Cream ☐ Syrup ☐ Other: _____

Dosage: Amount to be given:_____

Frequency: ☐ Every _____hours (time of previous dose:_____)

☐ Once a day at _____(time)

☐ As required

Duration: ☐ This medication is for today only (date:_____)

☐ This medication is ongoing: from_____to_____

Notes: _____

_____

_____

Please read important information over the page ……

Please Note:

Wherever possible, medication should be scheduled outside the school hours, e.g. medication required during a school day: it can be taken before and after school and before bed.

Medication delivered to the school:

Medication delivered to school:

Please ensure that medication delivered to the school:

□ Is in its original package

□ The Pharmacy label matches the information included in this form

Monitoring effects of medication:

Please note: School staff *do not monitor* the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.