BORONIA HEIGHTS PRIMARY SCHOOL

MEDICATION AUTHORITY FORM
For Temporary Medication

Child Name: ……..……..…. of Grade ……..…

needs to take ……..……..……(NAME OF MEDICATION)

Reason for Medication……..

They require ……..… (DOSE) To be given at ……(TIME)

Commencing …… /…… /…… Ending …… /…… /……

Medication is required: ❑ Daily ❑ As needed

I give permission for this medication to be administered by Boronia Heights Primary School staff.

SIGNED: …….. DATE: …….
(Parent/Guardian)

Below to be filled in by office staff when medication is given.

DATE	DOSE	TIME	SIGNED