



# CASTLE COVE PUBLIC SCHOOL

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## MEDICATION AUTHORITY FORM

THIS FORM IS TO BE COMPLETED FOR ALL MEDICATIONS INCLUDING PRESCRIPTION, NON PRESCRIPTION, HOMEOPATHIC AND HERBAL PREPARATIONS

### PARENTS TO COMPLETE THIS SECTION

*Please circle relevant statement*

- DAILY** medication to be administered for one day only
- ONGOING** medication to be administered for two or more days (eg. antibiotics, ADD medication, insulin)
- SYMPTOM DRIVEN** Medication to be administered when symptoms occur (eg. coughing, asthma)

<b>CHILD'S NAME</b>		<b>CLASS</b>	
<b>NAME OF MEDICATION</b>			
<b>DOSAGE</b>			
<b>SPECIAL INSTRUCTIONS</b> <i>*If symptom driven then outline signs for staff to look out for</i>			
<b>MEDICAL REASON FOR MEDICATION</b>			
<b>LENGTH OF COURSE AND TREATMENT</b>			
<b>PRESCRIBING DOCTOR'S/PRACTIONERS NAME</b>			
<b>PARENTS SIGNATURE</b>		<b>DATE</b>	

