I/We as parent/s or legal guardian of the student mentioned authorise the college to administer medication as detailed to my/our son/daughter. I/We agree to provide a supply of medication in a small container with the following details clearly marked on the container.

- Name of child
- Name of medication (must have a current pharmacy label)
- Quantity of medication to be given
- Storage directions

Parents are asked to bring this medication to the Office.

I/We accept that it is my/our responsibility to maintain an adequate supply of the medication at the college.

Any changes to this authority must be provided in writing to the college. I/We realise that it is my/our child’s responsibility to be present at the office at the appropriate time to take the medication. This form remains current until I/We advise you in writing.

Name of Parent/Legal Guardian: ..............................................................................................................................

Parent/s Signature: ........................................................................................................................................ Date: .........................

Daytime contact number: ..................................................................................................................................................
STUDENT ORAL MEDICATION AUTHORITY 2012

Authorisation for St Francis College, Crestmead to administer oral medication to my son / daughter.

CHILD’S DETAILS

Student Name: ........................................................................................................................................................................ Gender: ..............

Date of Birth: ........................................ Year & PC Group: ..........................................................

MEDICATION DETAILS

1. Name of medication ................................................................................................................................................................

2. When is medication to be administered:

   • MORNING TEA YES NO
     Dosage: ........................................................................................................................................................................

   • LUNCH YES NO
     Dosage: ........................................................................................................................................................................
     Other ...............................................................................................................................................................................

3. Special Instructions (if medication is not taken at prescribed time)

   ........................................................................................................................................................................

4. Other instructions concerning this medication (e.g. Must be taken with food etc...)

   ........................................................................................................................................................................

5. Do you authorise the school to administer the following?:

   • PARACETAMOL e.g. Panadol / Panamax YES NO
     Dosage: ........................................................................................................................................................................

   • VENTOLIN (asthma medication only) YES NO
     Dosage: ........................................................................................................................................................................
     (please state quantity and how often to be taken)

Does your child have any allergies, e.g. bee stings, insect bites, pollens etc. YES NO

* IF SO, PLEASE DETAIL AND SUPPLY THE OFFICE WITH CURRENT MEDICATION.

Dosage: ........................................................................................................................................................................

7. Does your child have an allergic reaction to any medication? Please detail below.

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