MEDICATION AUTHORITY FOR ILLNESS

(This Medication Authority is to be completed for medication administered on a temporary or spasmodic basis.) A new form will be required for each new type of medication.

Student's Name: _____

Date of Birth: _____

Name of prescribing Doctor: _____

Name of medication: _____

Doctor's instruction relating to administration: _____

_____

Dosage: _____ Time(s) for administration _____am/pm

Start Date: _____ End Date: _____

Is this medication to be used as required e.g. cream for skin irritation Yes / No

Parent/Caregivers Name: _____

Signature: _____ Date: _____

OFFICE USE ONLY

Scanned into student's record Yes / No

Date: _____

Staff entering data: _____

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