



AUTHORISATION TO ADMINISTER SHORT TERM MEDICATION

I(Parent/Guardian)

Authorise that my child..... Grade

Be given (Name of medication).....

Dosage.....

On the following dates.....

At the following times.....am/pm

Does the medication need to be refrigerated? Yes / No

Signed:..... Dated:.....

***** Please Note: All medication must be supplied in original packaging and clearly named *****
This authority is only valid for 5 days



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