### MEDICATION PERMISSION FORM

**NAME OF CHILD:** ……………………………………………………………………………

**GRADE:** …………………….. **TEACHER:** ………………………………………..

**TYPE OF MEDICATION:** …………………………………………………………………

**STORAGE REQUIREMENTS:** (e.g. fridge, cupboard, etc.)

……………………………………………………………………

……………………………………………………………………

**DOSAGE:** …………………………………………………………………………………

**TIME TO BE ADMINISTERED:** …………………………………………………………

**DAY / DAYS TO BE ADMINISTERED:** ………………………………………………

Signed: ……………………………… Date: ……………
(Mother/Father/Guardian)

Approved by: ………………………… Date: ……………
(Principal/Deputy Principal)

**Note:** Medication is usually administered by the Classroom Teacher or Office Staff.

**OFFICE USE ONLY**

*Date/s, Time/s and by whom medication given:*

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<th>Wed</th>
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(To be completed by person administering medication)

Revised 16/11/2012