LIDDIARD ROAD PRIMARY SCHOOL TRARALGON

AUTHORISATION TO ADMINISTER MEDICATION

STUDENT'S NAME: .....

I ..... authorise school staff to

administer the following medication to my child.

Name of medication: .....

Dosage: .....

Time: .....

Further instructions: .....

.....

Signed: .....(Parent/Guardian) Date:.....

Date & Signature of staff member administering medication