



APPENDIX: AUTHORISATION TO ADMINISTER MEDICATION FORM

NOTE: Students with Asthma or Anaphylactic conditions need to provide a separate Medical Plan.

My Child _____ of Year ___, is currently suffering from _____.

I/We authorise the staff at Emmaus Christian School to administer the following medication:

Name of Medication:	Is this a prescription medicine? Yes / No
How medication is to be administered:	
Is there any flexibility allowed in this timing?	
Dosage:	
Any special storage requirements:	
Start Date:	End Date:
Unused or expired medications will be disposed of by the school after this end date.	

Parent/Guardian Name

Signed

Date

Office Use: For PRESCRIPTION MEDICINES please check the following (circle)

Is in Original packaging?	Yes	Child's name on the label?	Yes
Is it in date?	Yes	Has the dose details	Yes
Entered on Denbigh?	Yes	Has the Doctors details?	Yes