Authority to Administer Medicine for a Short Duration of Time

Child's Name:_____ Class: _____

Medication Required & Reason:_____

Prescribing Doctor:_____

Period of Treatment: From: _____ To:_____

Dosage and Times Required:_____

Special Instructions: _____

I/We request that the staff of John XXIII Primary School and St Mark's Catholic College administer prescribed medication at school, during school hours, to my child (stated above) according to the medication details shown above. I/We accept and agree to observe the conditions imposed by the school and understand and agree that it is my/our responsibility to inform the Principal of any changes involving the administration of the medication.

_____ _____ _____

Parent/Guardian Signature Contact Phone Number Date

Office use only

	Monday			***Tuesday***			***Wednesday***			***Thursday***			***Friday***		
Wk	**Amt**	**Time**	**Init**	**Amt**	**Time**	**Init**	**Amt**	**Time**	**Init**	**Amt**	**Time**	**Init**	**Amt**	**Time**	**Init**
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