Sir David Brand School

Independent Public School

ABN: 12 582 538 74

MEDICATION AUTHORITY FORM

TO BE COMPLETED BY THE DOCTOR ONLY

COMPLETE ALL RELEVANT BOXES OR MEDICATION MAY NOT BE ADMINISTERED
PLEASES PRINT CLEARLY AND DO NOT USE MEDICAL TERMINOLOGY OR ABBREVIATIONS

NAME: ____________________ **ALLERGIES:** ____________________

PARENT/CARER SIGNATURE: ____________________ **DATE:** ____________________

REGULAR MEDICATION

MEDICATION Name & Strength	ROUTE	FREQUENCY					DOCTOR PRINT Name	DOCTOR SIGN Name	DATE Review/Cease
		Time							
		Dose					Ph:		
		Time							
		Dose					Ph:		
		Time							
		Dose					Ph:		
		Time							
		Dose					Ph:		
		Time							
		Dose					Ph:		