MEDICINE AUTHORITY FORM

Clearview Primary

Date: .....

Student's name: .....

I request that my child be given the following medication:

Time(s) when medicine is given

Procedure for giving medicine

Condition for which medicine is given

For the period of: ☐ **Days** ☐ **Until advised**

Name of prescribing doctor

I accept responsibility for:

- the decision to give this medication to my child, and acknowledge that the school is in no way responsible for that decision, now or in the future
- notifying the school about any changes in dosage, time, or procedures, by filling out a new Medicine Authority form
- delivering the medication personally to school
- ensuring that the medicine is not past its expiry date.

I accept that the school:

- may not have a trained medical officer to administer medications
- cannot guarantee that medication will be given at a precise time or by the same person
- will dispose of any uncollected medicine at the end of the year.

Parent/guardian's name

Signature	**Date**