Administration of Medication
Authorisation Form for Parent/Guardian

mecs
Mount Evelyn Christian School

Student's Name	Surname or family name First given name Second given name
Medication to be given to student during school hours (no injections or suppositories will be administered by First Aid Staff) (not required for Ventolin)	Name of Medication Dose and route (eg. 1 tablet, oral) Frequency (eg. As needed, after lunch etc) Duration of treatment (eg. 1 week, ongoing) Relation to meals or n/a (eg. after recess, before eating lunch) Side effects school staff should be made aware of Medication has been supplied in original container with the instructions provided by the pharmacist (necessary if this is prescribed medication) Yes ☐ No ☐
Parent signature	Parent's name (please print) Address Phone contact details: AH: MOB: AW: Signature: _____ Date: _____

IMPORTANT: ***Please notify school immediately of any change to details above.***