CASUAL MEDICATION AUTHORIZATION

CHILD'S NAME:  ........................................................................................................

Medication:  ...........................................................................................................

Dosage:  ...................................................................................................................

Time/s to be administered ......................................................................................

Dates Medication to be administered at school: .................................................
.................................................................................................................................

❖ This form is valid for the above dates only. If your child needs medication outside these dates, another completed Casual medication form is required.
❖ Medication must be in the original packaging with the Childs name and the dosage clearly marked.
❖ For prescription medication a letter from the doctor is also required stating Childs name and the dosage required.

I authorize the Staff Member delegated, to oversee my child take the prescribed medication listed above.
I understand that as the parent/guardian, I assume full responsibility for the taking and consequence of this medication, and that while every endeavor will be made to ensure that children take prescribed medication on time, the Staff of Cranbourne Primary School cannot be held responsible when medication is not taken.

NAME:  ....................................................................................................................

SIGNED:  ................................................................................................................

DATE:  ......................................................................................................................