MEDICINE AUTHORITY FORM

Students Name: _____

Class Teacher: _____

Room/Year: _____ **Date:** _____

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:

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**

St Michael's Catholic School
6 Beatrice Road, Remuera, Auckland 1050
Phone: (09) 520 0933 Email: secretary@smcs.school.nz