MEDICINE AUTHORITY FORM

West Rolleston Primary School
Te Kura o Te Uru Kōwhai

Student's name: .....

Studio teacher: .....

Studio/Year: ..... **Date** .....

I request that my child be given the following medication:

Time(s) when medicine is given

Details for giving medicine i.e quantity, length of time

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/expired medicine at the end of the year.

Parent/guardian's name

Signature	**Date**

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