BARTON PRIMARY SCHOOL

Medication Authority Form

Student's Name: _____ Date of Birth: _____

Student Class: _____ Nurse/Principal Signature: _____

Parent's Name: _____ Parent's Signature: _____

Medication required:

Name of Medication/s	Dosage (amount)	Time/s to be taken	How is it to be taken? (eg. orally/topical/injection)	Dates
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication
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