AUTHORITY FOR ADMINISTERING OVER THE COUNTER NON PRESCRIPTION MEDICATION

I, ___________________________ (Parent/Guardian) give authorisation for my child ___________________________ to be administered one dose of over the counter non prescription medications.

I understand that this authorisation is a guideline for the administration of a specific dose. I understand that I will be contacted for my permission to use these medications. Where students symptoms are not alleviated by the dose given, or in the event of an emergency, I agree to collect my child as soon as possible.

I understand the potential risks and side effects of this medication for my child.

Child's name: ___________________________

Name, form (tablet, liquid or cream), and strength of the medications:

- Trade Name: ___________________________
- Form and/or Strength: ___________________________

Dosage to be administered (one only): ___________________________

Condition or circumstance under which to be administered:

☐ Provide details: ___________________________

Doctor's name: ___________________________
Address: ___________________________
Phone No.: ___________________________

Emergency contacts names and numbers for child:

1. Name: ___________________________ Ph No.: ___________________________
2. Name: ___________________________ Ph No.: ___________________________

Parent/Guardian Signature: ___________________________
Parent/Guardian Name: ___________________________
Date: ___________________________