DAVID STREET SCHOOL
PERMISSION TO ADMINISTER MEDICATION FORM

I ____, being the Parent/Caregiver of
(Parent/Caregivers Name)

____________________________________ authorise David Street School Staff Members
(Students Name)

to administer medication to him/her for the following reason:

Medical Condition

Medication Details

The dosage and time for the medication are:

Dose

Time and/or Frequency

or as prescribed on the label (Please Tick If Applicable)

All medication will be held in the School Office or First Aid Room.

I understand that David Street School Staff will only administer medication under the guidelines of their Policies and Procedures.

Signed

Date

DAVID STREET SCHOOL
Kia Maia - Have Courage