**DONVALE PRIMARY SCHOOL**

**Medication Authority Form**
for a student who requires medication whilst at school

Student’s Name:_____________________________________________  Grade: __________

Parent’s Name:_________________________________________  Signature: ___________________________

Telephone: ______________________________

Please Note: wherever possible, medication should be scheduled outside the school hours, e.g. medication required three times a day is generally not required during a school day: it can be taken before and after school and before bed.

<table>
<thead>
<tr>
<th>Medication required:</th>
<th>Dosage (amount)</th>
<th>Time/s to be taken</th>
<th>Start date:</th>
<th>End Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Ongoing medication

**Medication Storage**

Please indicate if there are specific storage instructions for the medication:

________________________________________

________________________________________

**Medication delivered to the school**

Please ensure that medication delivered to the school:

☐ Is in its original package

☐ The pharmacy label matches the information included in this form.

**Monitoring effects of Medication**

Please note: School staff do not monitor the effects of medication and will seek emergency medical assistance if concerned about a student’s behaviour following medication.