

## MEDICAL AUTHORITY FORM

|                                  |                                       |
|----------------------------------|---------------------------------------|
| <b>Date</b>                      |                                       |
| <b>Student Name</b>              |                                       |
| <b>Medication Name</b>           |                                       |
| <b>Prescribed Dose</b>           |                                       |
| <b>Time to be given</b>          |                                       |
| <b>Last time given</b>           |                                       |
| <b>Period of Authorisation</b>   | From:     /     /     To:     /     / |
| <b>Comments</b>                  |                                       |
| <b>Parent/Guardian Signature</b> |                                       |

