MEDICATION AUTHORITY FORM E25 - SCHOOL

If you require **ANY MEDICATION** to be administered to your child, please hand this form along with the medication to the Office.

Name of Student: ……. **Grade:**……

Name of Medication to be Administered:……
*MUST BE IN ORIGINAL PACKAGING

Time/Times to be Administered:……**am** ……..**pm**

Dates of Medication to be Administered:……..

Storage Instructions: ……

Please Tick: ☐ I will pick up medication from the Office ☐Please send the medication home with my child

Parent Name: …… **Signature:**…….. **Date:**……