Lysterfield Primary School
Medication Authority Form
for a student who requires medication whilst at school

PARENT / GUARDIAN DETAILS

Parent/Guardian’s name: ____________________________________________

I hereby authorise the staff of Lysterfield Primary School to administer medication to my child as
detailed below. I understand the Medication needs to be in its original packaging and the
Pharmacy label needs to match the information detailed below.

Contact number/s during school hours: _____________________________________________

Signature: ___________________________ Date: ___________________________

CHILD’S DETAILS

Name:____________________________________________ Grade:___________

Name of Medication: _________________________________________________________

Reason for Medication: _______________________________________________________

__________________________________________________________________________

Type of Medication: (please circle) : Tablet Capsule Elixir Spray

Drops Puffer Cream Other: ______________________________

Dosage: Amount to be given: _________________ Time last dose was given: __________

Frequency: □ At 12.00 noon

□ At 1.00pm (With Lunch)

□ Every ___ hours

□ Once a day at _____________ (time)

□ Other __________________________

Duration: □ This medication is for today only (date: ____________)

□ This medication is ongoing from __________ to ____________

Medication pickup: □ I will pick this medication up from the office after school

□ Please send this medication home with my child after school

Storage: (Please indicate if there are specific storage instructions for this medication)