ISB Permission for Medication Form (v2.0)

Name of Student & Grade: _____ Date of Birth: _____

Diagnosis: _____

Regular Medication

The following medication(s) should be given at the time stated

Name of Medication: **Dosage:** **Time:** **Route:** **Duration:** **Special Instructions:**	**Name of Medication:** **Dosage:** **Time:** **Route:** **Duration:** **Special Instructions:**

As-required/Rescue Medication

Name of Medication: **Dosage:** **Route:** **For the following symptoms:**	**Name of Medication:** **Dosage:** **Route:** **For the following symptoms:**

Prescription-free medication

My child may receive the following (please circle as appropriate)

- Band aid OK
- Ibuprofen/Nurofen OK
- Antihistamine as liquid or tablet OK
- Other, please specify OK

: _____

Authorisation of the Parent/Legal guardian:

I give permission for the School Nurse/Teacher to administer the above medication.

Name of Parent/Guardian_____

Signature: _____ Date: _____

Record of Administration of Medicines

Date:	Time:	Name/Dosage of Medicine	Signature