PASADENA INTERMEDIATE SCHOOL
Medicine Authority Form

Child's Name: | **Date:**

Class Teacher: | **Room:**

MEDICATION

I request that my child be given the following medication at school:

Condition(s):	
Name of medication(s):	
Dosage and time(s) to be taken:	
Procedure for giving medicine:	

Name of the prescribing doctor:

I accept responsibility for:

- ☐ the decision to give this medication to my child, and acknowledge that the school is in no way responsible for that decision, now or in the future.
- ☐ notifying the school about any changes in dosage, time or procedures, by filling out a new Medicine Authority Form
- ☐ personally delivering the medication to school
- ☐ ensuring that the medicine is not past its expiration date

I accept that the school:

- ☐ may not have a trained medical officer to administer medications
- ☐ cannot guarantee that medication will be given at a precise time or by the same person
- ☐ will dispose any uncollected medicine at the end of the year

Parent/Guardian's Name:	
Date:	
Signature:	