Fullarton Park Community Centre

SCHOOL HOLIDAY PROGRAM

Medication Authorisation Form

THE CITY of Unley

CHILD DETAILS

First Name: _____ **Last Name:** _____

All medication needs to be:

- In the original container
- Clearly marked with child's name
- The dosage as per prescribed medication

Over the counter medication must be accompanied by authorisation from a Medical Practitioner with the above mentioned criteria outlined including a date range for which the medication is relevant.

PARENT / GUARDIAN TO COMPLETE THIS SECTION

Date: / /

Only medications prescribed in the child's name can be administered

Do you consent to your child self-administering their medication (please circle)? Yes / No

Name of medication: _____ Dosage required: _____

Type of medication: _____

Time to be administered or circumstances to be administered: _____

_____

Method of administration: _____

I _____ name of parent/guardian, give permission to staff of

Fullarton Park Centre School Holiday Program to administer the above medication.

Signed: _____ **Date:** _____

(Parent / Guardian)