St Therese's Primary School

Short Term Medication Authorisation Form

Name_____

Medication_____

Dosage_____

Date to be administered___/___/___until ___/___/___

Times to be administered_____

Date	Time	Staff Administered by

Authorised by_____ _____Date ____/_____/_____

Signature_____

Date Medication completed		To be filed in the office on

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