Medical Authority

Please note: A new Authority Form and Care Plan/s must be completed each year.

Child's Full Name:	**Campus:**
Oratory:	**Year:**

To Administer Medication
Name of Medication
Dosage and Frequency
Expiry Date of Medication

Asthma Action Plan	YES/NO	Anaphylaxis Plan Attached	YES/NO
Allergy Awareness Plan	YES/NO	Diabetes Plan	YES/NO
Epilepsy & Seizure Plan	YES/NO	Continence Care Plan Attached	YES/NO
Medication Plan	YES/NO	Oncology Patient Care Plan	YES/NO
Spina Bifida and Hydrocephalus Care Plan	YES/NO	Transfer & Positioning Care Plan	YES/NO
Permission for photo to be taken for medical identification	YES/NO	Requires assistance toileting	YES/NO

Other Specify_____

Parent/Guardian Name: _____ Relationship to Student: _____

Parent/Guardian Signature: _____ Date: _____/_____/_____