



ADMINISTRATION OF MEDICATION FORM

This form is to be used when a parent/carer requests school staff to administer medication to their child on a short term basis.

Note: Long term administration of medication should be incorporated in a health care plan.

School:

Year:

Form:

Students Name:

Date of Birth:

Family Contact Details
Address:

Gender:

Telephone No:

Teacher:

Section A: Medication Instructions – To be completed by parent/carer (Note: Medication must be provided by parents/carers)

Name of medication	Medication 1		Medication 2	
	Expiry date			
Dose/frequency – (may be as per the pharmacist's label)				
Duration (dates)	From : To:		From : To:	
Route of administration				
Administration Tick appropriate box	By self Requires assistance	<input type="checkbox"/> <input type="checkbox"/>	By self Requires assistance	<input type="checkbox"/> <input type="checkbox"/>
Storage instructions Tick appropriate box(es)	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Will staff need to be trained to administer your child's medication? Yes No If yes, describe the type of training the staff would require:

Section B – Authority to Act

This administration of medication form authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid for the specified time period as noted above.

Parent/Carer: _____

Date: _____

OFFICE USE ONLY

Date received: _____

Is specific staff training required? Yes No :

Type of training: _____

Training service provider: _____

Name of person/s to be trained: _____

Date of training: _____

