

FORM 3 - ADMINISTRATION OF MEDICATION

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)

	Medication 1		Medication 2	
Name of medication				
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 <input type="checkbox"/>	Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/>	Requires assistance <input type="checkbox"/>
Storage instructions Tick appropriate box(es)	Stored at school <input type="checkbox"/>	Kept and managed by self <input type="checkbox"/>	Refrigerate <input type="checkbox"/>	Keep out of sunlight <input type="checkbox"/>
	Other <input type="checkbox"/>		Other <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: _____

When this course of medication concludes, please retain this form in the student's school file.