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 p lan.

Student Name: Date of Birth:

Year:	Form	Gender:

Family Contact Details

Address: Telephone No :

Section A: Medication Instructions – To be completed b y 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 Requires assistance	☐ ☐	By self Requires assistance	☐ ☐
Storage instructions Tick appropriate box(es)	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

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: Date of training:

Name of person/s to be trained:

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

FORM