

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

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 <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"/>		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"/>	

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.

Form 12 - RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION

Name: _____ Date of Birth _____ Year: _____ Form: _____ Teacher: _____

RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION

Date	Time	Support/Medication	Staff Member	Signature/Initials

Record from: / / to: / /

Signed: _____ Date: / /