



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.

Student Name:

Date of Birth:

Year:

Form

Gender:

Family Contact Details

Address:

Telephone No:

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:

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.