

## 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"/>		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.

