

## 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)

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: \_\_\_\_\_



--	--	--	--	--

Record from:    /    /                    to :    /    /

Signed: \_\_\_\_\_

Date:    /    /