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)

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Medication 1</th>
<th>Medication 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expiry date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dose/frequency – (may be as per the pharmacist’s label)

<table>
<thead>
<tr>
<th>Duration (dates)</th>
<th>From:</th>
<th>To:</th>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
</table>

Route of administration

<table>
<thead>
<tr>
<th>Administration</th>
<th>By self</th>
<th>Requires assistance</th>
<th>By self</th>
<th>Requires assistance</th>
</tr>
</thead>
</table>

Storage instructions

<table>
<thead>
<tr>
<th>Tick appropriate box(es)</th>
<th>Stored at school</th>
<th>Kept and managed by self</th>
<th>Refrigerate</th>
<th>Keep out of sunlight</th>
<th>Other</th>
</tr>
</thead>
</table>

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.