

FORM 3 - ADMINISTRATION OF MEDICATION

This form is to be used when a parent requests the classroom teacher to supervise or administer medication on a short term basis. .

School: _____

Year: _____

Form: _____

Students Name: _____

Date of Birth: _____

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 Requires assistance	<input type="checkbox"/> <input type="checkbox"/>	By self Requires assistance	<input type="checkbox"/> <input type="checkbox"/>
Storage instructions (Tick appropriate box(es))	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Would 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 the school staff to follow my/our advice and/or medical practitioner. It is valid for the specified time period as noted above.

Parent/Carer: _____

Date: _____

OFFICE USE ONLY

Date received: _____

On conclusion of administration or supervision of medication file this form in the student's school file.

