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:

Insert Photo

Students Name: Date of Birth:

Address: Gender:

Telephone No: Teacher:

Section A: Medication Instructions– To be completed by parent/carer

	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 Requires assistance	☐ ☐	By self Requires assistance	☐ ☐
Storage instructions (Tick appropriate box(es)	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

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.