

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: Byford Primary 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 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	☐ ☐ ☐ ☐ ☐

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.

Form 12 - RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION

Name:	DOB	Year:	Form:	Teacher:
--------------	------------	--------------	--------------	-----------------

Name:	DOB	Year:	Form:	Teacher:
--------------	------------	--------------	--------------	-----------------

Name:	DOB	Year:	Form:	Teacher:
--------------	------------	--------------	--------------	-----------------

Name:	DOB	Year:	Form:	Teacher:
--------------	------------	--------------	--------------	-----------------

Name:	DOB	Year:	Form:	Teacher:
--------------	------------	--------------	--------------	-----------------

RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION	
---	--

[illegible]

Record from: / / to : / /

Signed: _____ Date: / /

Record from: / / to : / /

Signed: _____ Date: / /

Record from: / / to : / /

Signed: _____ Date: / /