FORM 3 - ADMINISTRATION OF MEDICATION

Willandra Primary School

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.

Students Name:	**Year:** **Form:**
Date of Birth:	Gender:
Parent Contact Details: Name: Address: Telephone No:	Teacher:

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

	Medication 1		Medication 2	
Name of medication				
Reason for 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 signature: 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: **Date of Birth:**

Year: **Form:** **Teacher:**

Date	Time	Support/Medication	Staff Member	Signature/Initials

Record from: / / to : / /

Parent signature: Date: / /