ADMINISTRATION OF MEDICATION – SHORT TERM USE

This form is to be used when a parent/carer request school staff to administer medication to their child on a short term basis – ie up to 2 weeks

Note: Long term administration of medication should be incorporated in a health care plan.

School: **EDEN HILL PRIMARY** Year: Room : Teacher:

Student's Name: Date of Birth: Gender:

Parent/Carer Name:

Address:

Telephone No: Home:

Work:

Mobile Number:

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:	
Method 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.

Signature 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.