



MEDICATION ADMINISTRATION AT SCHOOL

Name		Year	
Date of Birth		Home Room	

Staff need to be familiar with the medical needs of students for whom they have a duty of care, for this reason, the College requires either a diagnosis or reason for the need to administer medications at school.

Diagnosis/reason for administration:

Please list all medications that your child requires during school hours. Please also list medication administered at home.

	Medication 1		Medication 2		Medication 3	
Name of Medication						
Expiry date						
Dose/frequency (may be as per pharmacist's label)						
Duration (dates)	From: To:		From: To:		From: To:	
Route of administration						
Administration Tick appropriate box	By self <input type="checkbox"/>	Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/>	Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/>	Requires assistance <input type="checkbox"/>
Storage instructions Tick appropriate box(es)	Stored at school <input type="checkbox"/>	Kept & managed by self <input type="checkbox"/>	Refrigerate <input type="checkbox"/>	Keep out of sunlight <input type="checkbox"/>	Other <input type="checkbox"/>	
Other useful instructions or information/side effects						

I/We authorise College staff to provide health care support for my/our child.

Parents/Guardians Name: _____

Signature: _____

Date: _____

