FORM 3 – ADMINISTRATION OF MEDICATION (SHORT TERM)

*Note: this form is to be used when a parent/carer requests school staff to administer medication to their child on a **short-term basis**. Long term administration of medication should be incorporated in a health care plan.*

Name: **Date of birth:** **Year:** ☐ Day student ☐ Boarding student

Section A: Medication instructions

Note: medication must be provided by parent/carer AND this form to be completed by parent/carer

	Medication 1	Medication 2	Medication 3
Name of medication			
Expiry date			
Dose			
Time(s) & frequency			
Duration *(dates medication is required)*	Start: End:	Start: End:	Start: End:
Route of administration	☐ Oral ☐ Injection ☐ Topical ☐ Other:	☐ Oral ☐ Injection ☐ Topical ☐ Other:	☐ Oral ☐ Injection ☐ Topical ☐ Other:
Administration	☐ By self ☐ Requires assistance	☐ By self ☐ Requires assistance	☐ By self ☐ Requires assistance
Storage instructions	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*
Storage conditions	☐ Keep out of sunlight ☐ Refrigerate ☐ Other:	☐ Keep out of sunlight ☐ Refrigerate ☐ Other:	☐ Keep out of sunlight ☐ Refrigerate ☐ Other:

Section B: Staff training requirements

You may like to discuss with the principal or a medical practitioner

Is specific training for staff required to manage your child's condition or needs?

☐ Yes ☐ No

If yes, please describe:

Section C: 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.

Name of parent/carer:

Signature of parent/carer:

Date:

When complete, please attach the student health care summary form to the front of this document and return to your child's school.

OFFICE USE ONLY	
Date received:	Date uploaded on Compass:
Medication storage location:	
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.	