OFFICE USE ONLY

THE KING'S COLLEGE 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.

Students Name: Year: Form Class:

Height: Weight: Date of Birth:

Gender: Teacher:

Family Contact Details
Address: Telephone No:

Medical condition:

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	☐ ☐ ☐ ☐ ☐
Please list any side effects of this medication				

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

I hereby consent to The King's College staff administering medication to my child as detailed above. This administration of medication form authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid only for the specified time period as noted above.

Parent/Carer: Date:

_____ _____

AMINISTRATIVE STAFF 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:

RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION

Date	Time	Support/Medication	Staff Member	Signature/Initials

Record from: / / to : / /

Signed: _____ Date: / /