THE KING'S COLLEGE
Be exceptional.

ADMINISTRATION OF MEDICATION

Date:

Student Name:

Date of Birth: Form Class:

Parent Name:

Contact Number:

INSTRUCTIONS	MEDICATION 1	MEDICATION 2
Name of Medication		
Duration	Start: End:	Start: End:
Expiry date		
Dose/Frequency		
Administration	By self ☐ Requires assistance ☐	By self ☐ Requires assistance ☐
Storage	Kept in sickbay ☐ Managed by self ☐ Keep in a fridge ☐	Kept in sickbay ☐ Managed by self ☐ Keep in a fridge ☐
Will staff need to be trained to administer your child's medication?	☐ Yes ☐ No	☐ Yes ☐ No

This administration of medication form authorises school staff to follow my/our advice and/or that of our medical practitioner. Valid for the specified time period as noted above.

Parent/Carer Name	Signature
Received by Staff (Name)	Signature
Date Received	In original packaging? ❑ Yes ❑ No