ADMINISTRATION OF MEDICATION
Kingsway Christian College

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

School: Year: Form:

Students Name: Date of Birth:

Family Contact Details
Address: Gender:

Telephone No: Teacher:

Section A: Medication Instructions

In order for our staff to be able to administer medication to students it is necessary that ALL MEDICATION MUST BE SUPPLIED IN ORIGINAL CONTAINER WITH PHARMACY LABEL INTACT AND LEGIBLE, INCLUDING CHILDS NAME, NAME OF MEDICATION, DOSAGE PRESCRIBED, TIME TO BE GIVEN AND DATE OF PRESCRIPTION.

	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	

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.

Parent/Carer: _____ Date: _____

OFFICE USE ONLY

Date received: _____

Quantity of medication received: _____

Checked by (Print name): _____

Signature: _____

Witness: _____

Is specific staff training required? **Yes** **No** : Type of training if required:

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 Students file.

RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION
KINGSWAY CHRISTIAN COLLEGE

Name: Date of Birth Year: Form: Teacher:

Medication: Expiry Date:

RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION

Date	Time	Support/Medication	Staff Member	Signature/Initials

Record from: / / to : / /	
Signed: _____	Date: / /