Carson Street School

essn Education Support South Network

Carson Street School

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FORM 3 - ADMINISTRATION OF MEDICATION

This form is to be used when a parent requests the classroom teacher to supervise or administer medication on a short term basis.

School:	Year: Class:
Students	Date of Birth:
Address:	Gender:
Telephone No:	Teacher:

Section A: Medication Instructions– To be completed by parent/carer

	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	☐ ☐ ☐ ☐ ☐

Would 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 THE SCHOOL STAFF TO FOLLOW MY/OUR ADVICE AND/OR MEDICAL PRACTITIONER. IT IS VALID FOR THE SPECIFIED TIME PERIOD AS NOTED ABOVE.

PARENT/CARER:	DATE: / /

OFFICE USE ONLY

Date received:

On conclusion of administration or supervision of medication file this form in the student's school file.