Medication Administration Form

FORM 3B

Medications will not be given unless you complete and sign this form

Note: Medications must be in a new and original container as dispensed by the pharmacy

Student's Name

Class Name

Medical Condition

Medication Name

Last date medication needs to be taken

Dosage of medication

1. Medication use time

2. Medication use time (if applicable)

3. Medication use time (if applicable)

Self administration?

☐ Yes

☐ No

GP Telephone No.

Date medication dispensed by pharmacy

Special instructions:

Procedures to taken in an emergency (If applicable)

The above information is accurate at the time of writing and I give consent to school staff to administer medicine in accordance with the school policy. I will inform the school immediately if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent Name

Date

Email address

Signed

OFFICE USE ONLY: RECORDED ON MEDICAL TRACKER: ☐

DATE	TIME	DOSAGE	ADMINISTERED BY: