

**Administration of Prescribed Medication to a Student**

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name |  | Year |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication: (Name) |  | Expiry | Date Received |  |
| Medical Condition:  (relating to medication listed above) |  | | Quantity |  |
| Storage Information |  | |  |  |
| Name of Doctor |  | | Contact Ph: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Dosage |  | Time |  |
| Other information  (e.g. before food, after food, with lunch etc) |  | | |

**Details for Administration:**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent Name |  | | Telephone Contact Number |
| Parent Signature |  | Date |  |

***Office Use Only***

|  |  |  |  |
| --- | --- | --- | --- |
| **Prescribed Medications Form received (attach copy)** |  | **Teacher advised** |  |
| **ASCIA Plan / Health Care Plan (attach copy)** |  | **Other Allergies/Medical Conditions** |  |