

**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** |  |