





Medication Administration Form

The academy will not administer medicine unless you complete and sign this form.

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| --- | --- | --- | --- |
| Name of student:  |  | Form Group: |  |
|  |
| Date of birth:  |  | **Date form submitted:** |  |
|  |
| Name of parent: |  | **Parents signature / consent:** |  |
|  |
| Medical condition / illness:  |
|  |
| Medicine/s: *Please continue on another sheet if you require more space – this must be attached and signed*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name and type of medicine | Amount provided | Dosage, method and timing | Date dispensed  | Expiry date |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

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|  |
| Special precautions / other instructions: |
|  |
| Are there any side effects to the medication/s that the academy needs to know about? |
|  |
| Self-administration: *(delete as appropriate)* Yes / No  |
|

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| --- |
| To be completed by the academy:  |
| **Medication start date:** |  |
| **Medication end date:** |  |
| **Review to be initiated by:** |  |
| **Agreed review date:** |  |

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