





Medication Administration Form

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

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