FORM 3 - ADMINISTRATION OF MEDICATION

THIS FORM WILL USUALLY BE USED FOR SHORT TERM USE OF MEDICATION. IF STAFF TRAINING IS REQUIRED OR USE OF MEDICATION IS LONG TERM, A STANDARDISED OR GENERIC MANAGEMENT/EMERGENCY RESPONSE PLAN SHOULD BE COMPLETED.

STUDENT DETAILS

SCHOOL:	YEAR: FORM:	INSERT PHOTO HERE (If required)
NAME:	DATE OF BIRTH:	
ADDRESS:	GENDER:	
FAMILY CONTACT DETAILS	TEACHER:	
NAME:	**MEDICAL DETAILS**	
ADDRESS:	DOCTOR 1:	
RELATIONSHIP TO STUDENT:	DOCTOR 2:	TELEPHONE:
TELEPHONE: (W) (H) (M)	MEDICAL CENTRE:	
NAME:	PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE YES ☐ NO ☐	
ADDRESS:	DO YOU HAVE AMBULANCE COVER? YES ☐ NO ☐ **IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE.**	
RELATIONSHIP TO STUDENT:		
TELEPHONE: (W) (H) (M)	**STUDENT HAS A MEDICALERT BRACELET/PENDANT** YES ☐ NO ☐ IF YES PROVIDE DETAILS:	

STUDENT HEALTH CARE PLANNING – TO BE COMPLETED BY PARENT/CARER

HEALTH CARE CONDITION/NEED:

SECTION A – MEDICATION (IF APPLICABLE)

MEDICATION INFORMATION

	INSTRUCTIONS					
	MEDICATION 1		MEDICATION 2		MEDICATION 3	
NAME OF MEDICATION						
EXPIRY DATE						
DOSE/FREQUENCY – MAY BE AS PER THE PHARMACIST'S LABEL						
DURATION (DATES)	FROM : TO:		FROM : TO:		FROM : TO:	
ROUTE OF ADMINISTRATION						
ADMINISTRATION (TICK APPROPRIATE BOX)	BY SELF REQUIRES ASSISTANCE	☐ ☐	BY SELF REQUIRES ASSISTANCE	☐ ☐	BY SELF REQUIRES ASSISTANCE	☐ ☐
STORAGE INSTRUCTIONS (TICK APPROPRIATE BOX(ES))	STORED AT SCHOOL KEPT AND MANAGED BY SELF REFRIGERATE KEEP OUT OF SUNLIGHT OTHER	☐ ☐ ☐ ☐ ☐	STORED AT SCHOOL KEPT AND MANAGED BY SELF REFRIGERATE KEEP OUT OF SUNLIGHT OTHER	☐ ☐ ☐ ☐ ☐	STORED AT SCHOOL KEPT AND MANAGED BY SELF REFRIGERATE KEEP OUT OF SUNLIGHT OTHER	☐ ☐ ☐ ☐ ☐

PARENT/CARER SIGNATURE: ______________________________ PRINCIPAL SIGNATURE: __________________________

DATE: / /

NAME:	SCHOOL:	DOB:

SECTION B – AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, THE PARENT/CARER AND MEDICAL PRACTITIONER (IF REQUIRED).

PRINCIPAL: **DATE:**	**MEDICAL PRACTITIONER: (AT THE PRINCIPAL'S DISCRETION – SEE GUIDELINES)** **DATE:**
PARENT/CARER: **DATE:**	**REVIEW DATE:**

OFFICE USE ONLY

IS SPECIFIC STAFF TRAINING REQUIRED? **YES** ☐ **NO** ☐ DATE:

TYPE OF TRAINING:

NAME OF PERSONS TO BE TRAINED:

PRINCIPAL SIGNATURE: