

This form is required when a parent requests medication to be administered during school hours for a student or when no other medical management plan is in place. An Asthma Plan is an example of another medical management plan.

YEAR LEVEL OF CHILD	FIRST NAME	SURNAME
PARENT/GUARDIAN NAMES		PREFERRED CONTACT PHONE NUMBER
NAME OF EMERGENCY CONTACT		EMERGENCY CONTACT PHONE NUMBER
NAME OF DOCTOR		DOCTOR PHONE NUMBER

MEDICAL CONDITION: Please provide a brief description	SYMPTOMS: What specific symptoms do we need to be aware of?
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MEDICATION to be administered:	Dosage, Frequency and Method of administering:
	Duration e.g.: 3 days from ...

SPECIAL INSTRUCTIONS
Any special instructions for administering medication: eg: always shake bottle, after food, anything needed to settle student

- 1.
- 2.
- 3.
- 4.

PLEASE NOTE: No medication will be administered unless accompanied by this form.	PARENT/GUARDIAN SIGNATURE	DATE SIGNED
DESIGNATED MEDICATION ADMINISTRATOR	LOCATION OF MEDICATION	

MEDICATION ADMINISTERED REGISTER

DATE:	TIME IN:	WHO:	DATE:	TIME IN:	WHO:	DATE:	TIME IN:	WHO:
	TIME OUT:	WHO:		TIME OUT	WHO:		TIME OUT	WHO:
DATE:	TIME IN:	WHO:	DATE:	TIME IN:	WHO:	DATE:	TIME IN:	WHO:
	TIME OUT	WHO:		TIME OUT	WHO:		TIME OUT	WHO: