Medication Form

Student's Name: _____

Parent/s Name: _____

Grade: _____

Name of Medication: _____

Reason for Medication: _____

Specific Special Requirements: _____

Duration of Treatment: _____

Any untoward effect: _____

For tablets, quantity of tablets being sent to school: _____

Non-prescribed oral medications (e.g.: head-ache tablets) will not be administered by school staff unless parents complete this medication form. All student medications including prescriptions must be in the original containers and packaging, must be labelled and must have the quantity of tablets confirmed and documented.

Dosage: _____

Time/s to be given:_____

_____

I authorise staff at St. Joseph's Primary School to administer the above named medication to my child.

Signed: _____

Parent/s Name: _____

Date ____ / ____ / ____

MEDICATION ADMINISTRATION RECORD

Date	*Time*	*Medication*	*Dosage Given*	*Given By*	*Checked By*