APPLECROSS PRIMARY SCHOOL
FORM 3 - SHORT-TERM ADMINISTRATION OF MEDICATION

This form is to be used when a parent/carer requires school staff to administer medication to their child on a short-term basis (up to two weeks). Note: Long term administration of medication should be incorporated in a health care plan.

School: APPLECROSS PRIMARY SCHOOL **Year:** **Room No:**

Student's Name:

Parent/s Name/s:

Parent/s Mobile/s:

Address:

Section A: Medication Instructions - To be completed by parent/carer
Note: Medication must be provided by parents/carers, clearly labelled with student's full name.

	Medication 1		Medication 2	
NAME OF MEDICATION:				
FREQUENCY and DOSE: Tick appropriate box(es)	**Frequency:**	**Dose:**	**Frequency:**	**Dose:**
	☐ AM (Time:)		☐ AM (Time:)	
	☐ LUNCHTIME (Before / After)		☐ LUNCHTIME (Before / After)	
	☐ PM (Time:)		☐ PM (Time:)	
	☐ WHEN REQUIRED		☐ WHEN REQUIRED	
	☐ OTHER (Enter details below)		☐ OTHER (Enter details below)	
ADDITIONAL INSTRUCTIONS: With / Away from food? Max dose in 24hrs?	☐ OTHER		☐ OTHER	
DURATION:				
ADMINISTRATION:	☐ ORAL eg BY MOUTH ☐ OTHER eg SUBLINGAL, INHALATION		☐ ORAL eg BY MOUTH ☐ OTHER eg SUBLINGAL, INHALATION	
STORAGE INSTRUCTIONS:	☐ KEEP REFRIGERATED ☐ KEEP OUT OF SUNLIGHT ☐ OTHER		☐ KEEP REFRIGERATED ☐ KEEP OUT OF SUNLIGHT ☐ OTHER	

* ALL pharmacy/registered medications eg prescription **and** over-the-counter medications are to be stored and administered by School Staff only.

Section B - Authority to Act
This administration of medication form authorises school staff to follow my advise above/as per medical practitioner's instructions/plan attached. It is valid for the specified time period (up to two weeks) as noted above.

Parent/Carer Name: _____

Signature: **Date:**

OFFICE USE ONLY

Is specific staff training required? Yes ☐ No ☐ Type of training: _____

When this course of medication concludes, please retain this form in the student's school file.