Kennedy Baptist College

FOR OFFICE USE ONLY:

Date Received: ..... Entered: .....

Administration of Medication Form

This form is to be used when a parent/guardian requests college staff to administer medication to their child on a short-term basis. Note: Long term administration of medication should be incorporated in a Health Care Plan.

STUDENT DETAILS

First Name: ..... Surname: .....

Date of Birth: ..... Form Class: .....

HEALTH PRACTITIONER

Name of Practitioner: .....

Address: .....

..... Contact Number: .....

MEDICATION INFORMATION

Name of Medication:	
Expiry Date:	
Prescribed for: *(Medical Condition)*	
Storage Instructions:	☐ Stored at the Health Centre ☐ Keep out of sunlight ☐ Kept and managed by self ☐ Refrigerate ☐ Other: .....

ADMINISTRATION OF MEDICATION INFORMATION

Duration:	Start Date: End Date:
Dose or Frequency: *(As per the Pharmacist Label)*	
Route of Administration: *(e.g. Must be taken orally, injection)*	
Special Instructions: *(e.g. With food)*	

Assistance For Administering Medication Required?	☐ No, self-administer ☐ Yes, please ***Note: Schedule 8 medication are not allowed to be self-administered***
What Are You Requesting College Staff to do?	
Will Staff Need to be Trained to Administer the Medication?	☐ No ☐ Yes: Specify: .....

FURHTER INFORMATION

- Medication should be provided to the College in its original pharmacy packaging.
- Secure delivery of prescribed medications is important for the safety of all our students. Please name the person who will carry the medication to the College:

  .....
- For some medications and some students, it can be appropriate for them to carry their own medication to and from the College. For example, asthma reliever medication and pancreatic enzymes for cystic fibrosis.

  Note: The College may still need you to provide an additional supply of the medication for storage in central location/s within the College and for use should your child need help.

  - If you have selected the ***Self-Administration of Medication*** option above the Principal (or his/her delegate) will review the request. If there are any concerns, you will be contacted.
  - If applicable, please describe where and how your child will carry this medication, for example, my child will carry it on their person in a medical pouch:

    .....
  - Your child's medication must be clearly labelled with their name and form class.

PARENT PERMISSION AND DECLARATION

The ***Administration of Medication Form*** authorises the College staff to follow my/our advice and/or that of our medical practitioner. It is valid for the specified time period as noted on this form.

I declare that medical approval for the listed medication above have been obtained from the medical practitioner as indicated in this form.

Kennedy Baptist College reserves the right to request further information from the medical practitioner should more information be required

Parent/Guardian Name and Surname: .....

Signature: ..... *Date:* .....