

Administering Prescribed Medication

To be completed by the student's parent/carer

Date:

STUDENT DETAILS

Family name: Given name(s):

Class:

MEDICAL INFORMATION

My child has the following health/medical condition:

.....

Is this an ongoing health/medical condition: Yes No

If **Yes** please discuss with us whether an Individual Medical Plan is necessary.

MEDICATION INFORMATION

(Please label all medication with the child's name, dose & expiry date)

Medication Name:

Batch # (For Epi Pens)

Expiry date: Dosage:

Period of Administration, from:(date) to:(date)

What time/s of day should the medication be given?

Does this medication need to be:

Stored in the refrigerator: Yes No

Taken with food or water: Yes No

Further information:

.....

Signed by Parent/Carer: _____ Date: _____

