Silver Tree
STEINER SCHOOL

ADMINISTRATION OF MEDICATION

This form is to be used when a parent/guardian requests school staff to administer medication to their child on a short term basis (up to 2 weeks).
Note: Long term administration of medication should be incorporated in a Health Care Management Plan.

Student Name: **DOB:** **Class:**

Parent/Guardian: **Phone number:**

Section A – Medication Instructions - To be completed by parent/guardian (Note: Medication must be provided by parent/guardian)

	Medication 1		**Medication 2**	
Name of medication				
Expiry date				
Dose/frequency – (may be as per the pharmacist's label)				
Duration (dates)	From: To:		From: To:	
Route of administration				
Storage instructions Tick appropriate box(es) *Medication to be handed to the office or classroom teacher for safe keeping.*	Stored at school Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐	Stored at school Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐

Will staff need to be trained to administer your child's medication? Yes ☐ No ☐

If yes, describe the type of training staff would require:

Section E –Authority to Act.

The administration of medication form authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid for the specified time period as noted above.

Parent/Guardian: Date:

OFFICE USE ONLY

Date received:

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

Training service provider: Name of person/s to be trained:

Date of training:

RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION

Date	Time	Support/Medication	Staff Member	Signature/Initials

Please file with Student Record when complete