

Medication Administration Form

The academy will not administer medicine unless you complete and sign this form.

Name of student:		Form Group:		
Date of birth:		Date form submitted:		
Name of parent:		Parents signature / consent:		
Medical condition / illness:				
Medicine/s: Please continue on another sheet if you require more space – this must be attached and signed				
Name and type of medicine	Amount provided	Dosage, method and timing	Date dispensed	Expiry date
Special precautions / other instructions:				
Are there any side effects to the medication/s that the academy needs to know about?				
Self-administration: (delete as appropriate) Yes / No				
To be completed by the academy:				
Medication start date:				
Medication end date:				
Review to be initiated by:				
Agreed review date:				