FORM 3 - ADMINISTRATION OF MEDICATION

THIS FORM WILL USUALLY BE USED FOR SHORT TERM USE OF MEDICATION.
(If staff training is required or use of medication is long term, a standardised or generic management/emergency response plan should be completed. Please see office staff.)

STUDENT DETAILS								
SCHOOL: Millen Primary School		YEAR::		ROOM:				
STUDENT NAME:		DATE OF BIRTH:						
FAMILY CONTACT DETAILS								
PARENT 1 NAME:		PARENT 2 NAME:						
RELATIONSHIP TO STUDENT:		RELATIONSHIP TO STUDENT:						
TELEPHONE:		TELEPHONE:						
STUDENT HEALTH		I CARE PLANNING:						
HEALTH CARE CONDITION/NEED:								
SECTION A – MEDICATION (IF APPLICABLE)								
MEDICATION INFORMATION								
	INSTRUCTIONS							
	MEDICATION 1		MEDICATION 2		MEDICATION 3			
NAME OF MEDICATION								
EXPIRY DATE								
DOSE/FREQUENCY – MAY BE AS PER THE PHARMACIST'S LABEL								
DURATION (DATES)	FROM: TO:		FROM: TO:		FROM: TO:			
ROUTE OF ADMINISTRATION								
ADMINISTRATION (TICK APPROPRIATE BOX)	BY SELF REQUIRES ASSISTANCE		BY SELF REQUIRES ASSISTANCE		BY SELF REQUIRES ASSISTANCE			
STORAGE INSTRUCTIONS (TICK APPROPRIATE BOX(ES)	STORED AT SCHOOL KEPT AND MANAGED		STORED AT SCHOOL KEPT AND MANAGED		STORED AT SCHOOL KEPT AND MANAGED			
	BY SELF REFRIGERATE		BY SELF REFRIGERATE		BY SELF REFRIGERATE			
	KEEP OUT OF		KEEP OUT OF		KEEP OUT OF	_		
	SUNLIGHT		SUNLIGHT OTHER		SUNLIGHT OTHER			
PARENT/CARER SIGNATURE:								

STUDENT NAME:	DOB:	SCHOOL: Millen Primary					
SECTION B – AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, THE PARENT/CARER AND MEDICAL PRACTITIONER (IF REQUIRED).							
PRINCIPAL:		PRACTITIONER: (AT THE PRINCIPAL'S ION – SEE GUIDELINES)					
DATE:	DATE:						
PARENT/CARER:	REVIEW	DATE:					
DATE:							
OFFICE USE ONLY							
IS SPECIFIC STAFF TRAINING REQUIRED?	YES NO	DATE:					
DATE.							
TYPE OF TRAINING:							
NAME OF REPORTS TO BE TRAINED							
NAME OF PERSONS TO BE TRAINED:							
PRINCIPAL SIGNATURE:							
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