Department of Education

ADMINISTRATION OF 'AS REQUIRED' MEDICATION

Mount Lawley Primary School — Strive for Wisdom

For Parents / Carers to provide permission for Mount Lawley Primary School staff to administer medication required on an as required basis ie: Panadol to keep at school for headaches etc.

Student Photo Here	**Name:** _____ **Date of Birth:** ____/_____/_____ **Faction:** _____ **Year Group:** ___ **Form:** _____ **Teacher/s:** _____ **Reason for Medication:** _____

Medication is to be provided as below

- In the correct dosage, clearly labelled with the child's name & original packaging
- Documentation must be signed and dated by a parent/carer at the Front Office each time medication is provided to the school.

SECTION A: Medication Instructions (Note: All medication must be provided by parents/carers)								
	Medication 1			Medication 2			Medication 3		
Name of medication								
Expiry date	___/_____/____			___/_____/____			___/_____/____		
Dose to be administered								
Time to be administered								
Duration (dates)	___/_____/____ To ___/_____/____ (no later than the end of the current year)			___/_____/____ To ___/_____/____ (no later than the end of the current year)			___/_____/____ To ___/_____/____ (no later than the end of the current year)		
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 & Self-Managed Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐		Stored at school Kept & Self-Managed Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐		Stored at school Kept & Self-Managed Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	

SECTION B: Authority to Act

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

SECTION C: Medical Practitioner to Complete (If required)

Medical Practitioner Name: _____ Medical Practice: _____

Provider Number: _____

Signature: _____ Date: _____/_____/_____

SECTION D: Parent / Guardian to Complete

Parent/Carer Name: _____ Relationship To Student: _____

Signature: _____ Date: ___/_____/____

ADDITIONAL NOTES:

OFFICE USE ONLY

Received By: _____ Date Received: _____/_____/_____

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

Name of person/s to be trained: _____

Training service provider: _____

Date Training Completed: _____/_____/_____

- ☐ Updated Student Records in Compass
- ☐ Updated Medication Records in Compass
- ☐ Upload other relevant documentation to Compass
- ☐
- ☐
- ☐
- ☐ Medical Bag Created
- ☐ Form 12 Created
- ☐ Teachers Notified
- ☐ Print Evacuation / Lockdown File Medical Book
- ☐
- ☐

Processed By: _____ Date Processed: _____/_____/_____

FORM MUST BE KEPT IN STUDENT FILE ONCE MEDICATION CONCLUDES.