Department of Education

FORM 11: ADMINISTRATION OF LONGTERM & ONGOING 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 a long-term basis ie: ADHD Medication etc.

This does not include medication for Allergies, Asthma or Anaphylaxis.

Please ensure your child's classroom teacher, specialist teachers and Student Services Coordinator (Jared Lawson) have been advised of the details of your child's administration of medication schedule.

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 a diagnosis has not been provided to the school)

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: _____/_____/_____

☐ Diagnosis Received	☐ Medical Bag Created
☐ Updated Student Records in Compass	☐ Form 12 Created
☐ Updated Medication Records in Compass	☐ Teachers Notified
☐ Upload Diagnosis Report	☐ Reprint Evacuation / Lockdown File Medical Book
☐ Upload Form 11 to Compass	☐
☐ Upload other relevant documentation to Compass	☐

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

FORM MUST BE KEPT IN STUDENT FILE ONCE MEDICATION CONCLUDES.