Medication Administration Form

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

Name of student:		**Group / class / form:**	
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:	