



Medication Administration Form

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

Name of student:		1	Group / class / form:		"	
						-
Date of birth:			Date form subn	nitted:		
Name of parent:			Parents signature / consent:			
Medical condition / illness:						
Medical Condition / Illness:						
Medicine/s: Please continue	on another s	heet if you requ	ire more space – t	his must	be attache	d and signed
Name and type of Amount medicine provided			Dosage, method and timing		nsed	Expiry date
					155 P Matter Secretary and a second a second and a second a second and	
,						
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						
Seit-administration: (delete	as appropria	te) Yes / No	•			
4			101	oe compi	eted by the	e academy:
Medication start date:						
Medication end date:						
Review to be in				and an exercise or for each		
Agreed re						