Joondalup
Education Support Centre
Independent Public School

Learning for Life

# ADMINISTRATION OF SHORT TERM PRESCRIBED MEDICATION CONSENT FORM

(to be completed by parent)

*Student Details*

STUDENT NAME _____ (Surname) _____ (First Name)

DATE OF BIRTH: _____

YEAR: _____

CLASS TEACHER: _____

*Medication Details:*

NAME OF MEDICATION _____

*Medication to be kept in the pharmacy container labelled with the name of the drug, name of the student, the dose and frequency of administration.*

EXPIRY DATE OF MEDICATION: _____

COMMENCEMENT DATE: _____

CONCLUSION DATE: _____

WHEN TO ADMINISTER: *(frequency, how much/dose)*

WHO TO ADMINISTER: _____

*Person signing below if staff member*

I verify that I have read this document and agree with implementation as outlined.

Parent's Name: _____

Parent's Signature: _____ Date: _____

Staff Member's Name: _____

Staff Member's Signature: _____ Date: _____

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