



MEDICATION ADMINISTRATION FORM

Parental Authorisation (To be completed by the parent)

Child's Name: _____

Medication: _____
(Name that appears on label)

Reason for medication: _____

- 1. Dosage: _____
- 2. Time/Frequency: _____
- 2. Method: _____
- 4. How many days to be given? Mon Tue Wed Thurs Fri.
- 5. Ongoing: YES NO
- 6. Amount supplied - Number Tablets _____
- Number of mls _____

Possible side-effects:

Details from Medical Practitioner regarding circumstances of use:

Parental/Guardian Signature: _____ **Date:** _____

Staff Action:
Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			

ST BERNADETTE'S CATHOLIC PRIMARY SCHOOL

Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			

Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			

Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			