SHORT TERM / INFREQUENT MEDICATION FORM

I authorise the teacher, sick bay employee or office staff to administer the following medication to my child:

Student's Name: ……**Date of Birth**: ……..…….....

Medication: ……..……. **Dose**: ……...……

Storage of Medication……

Please ensure that medication delivered to KEPS is (please tick):

☐ In original packaging; and
☐ The pharmacy label matches information included in this form.

Dates to be given: …….…….

Times to be given: …….……

How is medication taken…….....

Signed: …….. (Parent/Guardian)

Date: …….

MEDICATION ADMINISTRATION LOG (for school use only)

Date	*Time*	*Medication & dose*	*Medication taken e.g. orally*	*Staff Member administering*