Medication Administration Form

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

Name of Child:		**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:	