SCHOOL MEDICATION RECORD

Student Name: _____ Student Date of Birth: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Route of Administration: _____

Prescribing Healthcare Practitioner: _____

Original Script or Doctor's Authority Sighted and Copy Attached (**required for all Schedule 8 medications**): Yes ☐

Original Packaging Supplied: Yes ☐

Reason for Medication: _____

Start Date: _____ End Date: _____

(If the medication is ongoing, a new School Medication Record will need to be provided each year)

Administration Instructions: _____

_____

Possible Side Effects: _____

Allergies or Other Medications: _____

Parent Name: _____

Parent Contact Information:

Phone: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Please note:

Medication must be in its original container with the original label showing the student's name, medication name, dosage, and frequency of administration.

If there are any changes in medication or dosage, a new script or doctor's authority will need to be provided.

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Office Use Only:

The parent's written authorisation to administer medication must be sighted.

The school nurse or designated staff member must monitor student self-administration of medication and documenting it on this form / Seqta.