MEDICATION ADMINISTRATION FORM

To be completed for students who require medication during school hours.

Student Personal Information

Legal Name Family Name/Surname	First Name	Middle Name (if applicable)	Preferred Name:
☐ Male ☐ Female	**Date of Birth (dd/mm/yyyy)**	**Grade / Class**	

Medication Information

1. Diagnosis / reason for medication: _____

_____

2. Name of medication: _____

_____

3. Dosage / how much medication to be given: _____

4. Route (oral / injection / skin): _____

5. Time(s) for medication to be given: _____

6. Start date (dd/mm/yyyy): _____ End date: (dd/mm/yyyy): _____

7. Special instructions: _____

_____

_____

8. Other important information: _____

_____

_____

_____	_____	_____
Parent/Guardian Name (PRINT)	Parent/Guardian Signature	Date (DD/MM/YYYY)