KIALLA CENTRAL PRIMARY SCHOOL
SHORT TERM MEDICATION ADMINISTRATION FORM

Details of medication to be administered

Date _____

Student's name _____

Grade _____

Reason for Medication _____

Medication _____

Dosage _____

Time to be administered_____

Medication will need to be administered until: Date _____

Medication needs to be kept in the refrigerator: YES / NO

Date	Dosage	Time Administered	Staff Signature (Administering)	Checked by

PARENTS/CARERS PLEASE REMEMBER TO COLLECT UNUSED MEDICATION AT THE END OF YOUR CHILD'S TREATMENT.

Parent / Carer _____ Date _____

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