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

Parent / Carer _____ Date _____

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

Date	Dosage	Time Administered	Print name & initial staff administering	Print name & initial staff checking

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