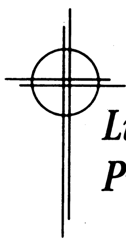

111 Whitelaw Avenue
Delacombe 3356

Phone: (03) 5336 2015
Fax: (03) 5335 5160

MEDICATION ADMINISTRATION AUTHORITY

STUDENT'S NAME		**CLASS**	

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby authorise Lumen Christi Primary School to administer medication to my child as prescribed by

_______________________ (See Below)

Doctor's Name

Please list all medication your child is taking at home _______________________

____

Signed _______________________ Date _______________

Print Name _______________________ Daytime Contact No _______________

TO BE COMPLETED BY DOCTOR

Diagnosis _______________________

Drug ___________ Dosage ___________ Route ___________ Time/Freq ___________

If PRN, state frequency or indication _______________________

Duration of Treatment _______________________

Possible side effects and adverse reaction _______________________

____

Other Recommendations _______________________

____

Doctor's Name (please print) _______________________

Contact Phone No _______________________ Fax No _______________

Doctor's Signature _______________________

Document 10.2

ADMINISTRATION RECORD

Student's Name: ……………………………………………………………..

Drug: ………………………………………………… Strength: …………………………………………..

Quantity: …………………………………………… Frequency: ………………………………………...

Date	Time	Comment	Dispensed /Received	Balance	Given By	Checked

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Primary School

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OCCASIONAL MEDICATION ADMINISTRATION RECORD
(eg antibiotics, cough mixture etc)

N.B. Medication must be accompanied by a signed note from parent requesting administration.

Must also state dosage & timing (unless prescription medication has instructions on label).

Note to be file chronologically in folder.

Date	Time	Student's Name	Drug & Qty Dispensed	Given By	Checked

Document 10.2