WEST PARK ACADEMY

MEDICATION ADMINISTRATION FORM

I, ... [parent/guardian] request that

..... [child's name] has the following prescribed medications administered everyday/when required.

Name of medication	Dosage/method of administration	Everyday	As required

I understand that only medications prescribed by a registered practitioner can be administered.

I agree that I will personally ensure that the prescribed medications to be administered are delivered to the school main office.

I recognise that without a completed Medication Administration Form the medication will not be administered.

Signed.....Print.....

Date.....Contact number.....

WEST PARK ACADEMY

MEDICATION ADMINISTRATION FORM

Record of Administration of prescribed medication

Child's Name..

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Date					
Medication Administered					
Initials					

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Date					
Medication Administered					
Initials					

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Date					
Medication Administered					
Initials					

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Date					
Medication Administered					
Initials					

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Date					
Medication Administered					
Initials					