



ADMINISTRATION OF MEDICATION CONSENT FORM

Name: _____ Date of Birth: _____ Class: _____

Medication: _____

Dose: _____

Frequency: As required or
 Regular dose every _____ hours or
 Regular dose set time _____ am/pm _____ am/pm

Start Date: _____ End Date: _____ or ongoing

The administration of any new medications is to be commenced at home in case of any allergic reactions or adverse effects.

Duration of Prescription: _____

Prescribing Doctor: _____

Indication for Use: _____

I consent to authorised Ormiston College staff administering the above medication to my child as directed on the prescription.

Parent Name: _____

Signature: _____ Date: _____

OFFICE

The medication supplied corresponds with the details on this form.

Staff Name: _____

Signature: _____ Date: _____

NB. This form is to be scanned and attached to the student's electronic medical record.

Authorised Ormiston College staff will document medication administration in the student's electronic medical record in accordance with the Ormiston College Administration of Medication Policy.