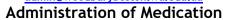
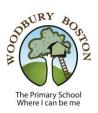
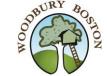
Woodbury Boston Primary School 11 Shelley Beach Road Kronkup WA 6330 admin@woodburyboston.wa.edu.au





Student Details						
Student Name						
Date of Birth			Class			
Medication Information						
(medication to be provided by parent/carer)						
Name of Medication						
Reason for Medication						
Expiry Date / /	To be take		n date / /	To be ta	ken until date / /	
Dose amount, frequency, time of day to be taken, etc						
Has this medication been prescribed or recommended by a Medical Professional? Yes No If yes, please attach note from medical professional						
Administration			d can self-administer			
Tick appropriate box Storage Instructions		<u>a requires some assis</u> ed by staff	equires some assistance			
Tick appropriate box(es)			igerate			
Tren appropriate box(es)			out of sunlight			
		Oth				
		Kep	t and managed by chi	ld (Epipen:	s and asthma inhalers only)	
Will staff need to be trained to administer your child's medication						
Paracetamol and antihistamines are held by the school and do not need to be provided by parents/carers. Please describe under what circumstances Paracetamol and/or antihistamines are to be given to your child (if any)						
Authority to Act						
I(parent/carer name) give permission for school staff to administer the above medication to my child following the instructions I have provided.						
Parent / carer signature		Date				
Staff Use Only						
Staff Use Only						
Date form received / /	Staff member sign		Date medication r	eceived	Staff member sign	
Is specific staff training required Yes No			Type of Training			
Training provider and date			Staff member/s trained			

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Administration of Medication

RECORD OF HEALTH CARE PROCEDURES OR ADMINISTRATION OF MEDICATION No of Tabs Checked Initials Procedure / Medication Staff Member Date Time remain

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