

**SHORT TERM MEDICATION FORM**

**For example – Antibiotics (4 x per day only)**

**Please note: Medicine must be prescribed by a Doctor and must be in date and supplied in the original container/packaging, labelled with the prescription label showing child’s name and dosage.**

**Name of Child:** ………………………………………………………………………………….

**DOB:** …………………………………………………….………

**Name of Medicine required:** …………………………………………………………

**Dosage:** …………………………………………………………

**Time of last dosage at home before school** (please notify the office if this is different on any day):

……………………………………………………………………………………………

**Time to be given in school:** …………………………………………………………………………….

**Specific Requirements** (eg on an empty stomach): ……………………………………………………………………………………………

**Storage Advice** (eg refrigerated): .………………………………………………………………………………………………………………………

**Medication start date:** …………………………………………………………………

**Duration:** ……………………………………………………

**Last date of Medication in school:** .………………………………………..

**Any known side effects of this medication for your child:** …………………………………………………………………………

**Parent/Carer Signature:** …………………………………………………..…

**Date:** ……………………………………………………………….…..

**Safe disposal of medicine.**

**Medicine returned to parent:**

**Date:** ……………………………………………………………….…..

**Parent/Carer Signature:** …………………………………………………..…