ST MARY'S PRIMARY SCHOOL, DONNYBROOK

Schedule 1 – School Medication Record

Student Information	
Student name:	
Date of birth:	
Medication Information	
Name of medication:	
Dosage:	Frequency:
Route of administration:	
Prescribing Healthcare Practitioner:	
Original script or authority sighted and copy attached: ☐ Yes	
Reason for medication:	
Start date:	End date:
Administration instructions:	
Possible side effects:	
Allergies or other medications:	
Parent Information	
Parent name:	
Phone:	Email:
Signature:	Date:
Emergency Contact	
Name:	Phone:
School Nurse or Designated Staff Member Signature	
Signature:	Date:
Notes	
• Medication must be in its original container, labeled with the student's name, medication name, dosage and frequency of administration.	
• The parent's written authorisation to administer medication must be sighted.	
• The school nurse or designated staff member must monitor student self-administration of medication and documenting it on this form.	
• The parent must immediately notify any changes in medication or dosage.	

Staff Signature	
Signature:	Date:

Administration of Medication – Office Use only

Date	Med/Dose	Administering Staff	Witness

https://cewaedu.sharepoint.com/sites/Handbook/SitePages/Administration-of-Medication.aspx