Short Term Medication Plan and Agreement

For short term use only 14 calendar days or less

Pupil Information	
Pupil Name:	Date of Birth:
Gender:	Class:

Medication Information	
Medication: (Copy wording from container)	Medication:
Dose:	Dose:
Method of administration:	Method of administration:
Timing(s):	Timing(s):
Expiry date:	Expiry date:

Parental Agreement	
I have requested and authorise the staff to administer the medication as stated above. I also agree to notify the school immediately of any changes to the requirement to administer the above medication. The medicine is provided in its original container and is within expiry date.	
Name:	Signature:
Relationship to pupil:	Date:
Day phone number:	Mobile:

The school may require that this medication plan is authorised by your GP or other health professional

Healthcare Professional Agreement (If required)	
I agree that the medication prescribed is necessary for this child	
Name:	Signature:
Job Title:	Date:

School Agreement	
The school will administer the medications detailed above as requested.	
Name:	Signature:
Job title:	Date: