Casuarina Steiner School
Inspiring the Head, Reaching the Heart

Medication Administration by Staff

I _____ request staff at Casuarina Steiner School to administer the following medication to my child.

Name of child: _____ DOB: _____

Has your child taken this medication before? if so when _____ were there any side effects?
Yes / No Details _____

Name of Medication _____ Expiry Date _____

Medication prescribed for _____

Dose to be administered _____ Method of administration _____

Time last administered_____ Time to be administered _____

Signature _____ Date _____

Record of Administration of Medication

Child's name _____

Date	Name of Medication	Dose Given	Time Given	Method	Name & Signature of person administering medication	Name & Signature of witness

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