BHCS STUDENT MEDICATION REGISTER 2015

CHILD’S FULL NAME: _____________________________________________ CLASS: _________

MEDICAL CONDITION: ____________________________________________

NAME OF MEDICATION: ____________________________________________

EXPIRY DATE: ______________________

SEVERITY OF CONDITION

☐ Mild
☐ Moderate *
☐ Severe **

*If you have indicated moderate, an Action Plan would be preferable
**If you have indicated severe an Action Plan is compulsory

SIGNS & SYMPTOMS

________________________________________________________________________________
________________________________________________________________________________

REQUIRED DOSAGE

________________________________________________________________________________

DAILY    WEEKLY    MONTHLY    AS REQUIRED

☐ ☐ ☐ ☐

WHERE IS THE MEDICATION TO BE KEPT?

Sick Bay*   Teacher’s Office   Student’s Bag or Locker   Kindergarten First Aid

☐ ☐ ☐ ☐

*compulsory for Primary students unless discussed otherwise

HAVE YOU SUPPLIED THE SCHOOL WITH A LETTER OF AUTHORISATION? (If applicable)
For the administration of such medicine
☐ Yes       ☐ No

PARENT/GUARDIAN NAME: ____________________________________________

PARENT/GUARDIAN SIGNATURE: _______________________________________

DATE: ______ / ______ / _______