Melbourne Archdiocese
Catholic Schools

Holy Trinity Medication Authority Form

This form is to be completed where parents/carers request that a student is administered medication at school or during a school activity. The principal or their delegate must approve all ongoing and regular administration of medication (over the counter or prescription) by the school and in most cases, medication must not be administered to a child being educated and cared for unless this form is signed by an AHPRA registered medical practitioner or pharmacist.

The principal or delegate may agree to proceed with the authority of parent/guardian/carer signature without the authority of an AHPRA registered medical practitioner or pharmacist. This would only occur in rare cases, for example, short term (1-2 days) administration of over-the-counter medication at school or on off-site activities such as camps. No medication will be administered beyond the instruction on the original packaging unless recommended by an AHPRA registered medical practitioner or pharmacist.

Schools require written permission for students to self-administer their medication from parents/guardians, in consultation with registered medical or health practitioners to determine appropriate age and situation under which the student can self-administer their medication.

Parents/carers must ensure that medication brought to the school is in its original package with original labels. Please note, school staff will seek emergency medical assistance if there are concerns about a student's condition following the administration of medication.

Student details					
Name of student				Date of birth	
Date of Medical Management Plan (if relevant)		MedicAlert Number (if applicable)		Date for Medication Authority Form	

Requirement for medication to be administered at school
Please outline the reasons for the administration of medication at school. For ongoing medical conditions, this should generally be supported by a Medical Management Plan or a letter from the student's treating health practitioner (e.g. diagnosis of ADHD requiring administration of Ritalin at school) (see the school's Medical Management Policy for further information). For short term use or once off (1-2 days), please also describe the reasons for administration of medication at school.

Medication to be administered at school					
Name of Medication	**Dates to be administered** ☐ Ongoing ☐ Short term Start: …….. End …….	**Time/s to be taken**	**Dosage**	**Method (e.g. topical, oral, injected)**	**Supervision required?** ☐ No – self managed by student ☐ Yes ☐ Remind ☐ Observe ☐ Assist ☐ Administer
Name of Medication	**Dates to be administered** ☐ Ongoing ☐ Short term Start: …….. End …….	**Time/s to be taken**	**Dosage**	**Method (e.g. topical, oral, injected)**	**Supervision required?** ☐ No – self managed by student ☐ Yes ☐ Remind ☐ Observe ☐ Assist ☐ Administer

Name of Medication	Dates to be administered ☐ Ongoing ☐ Short term Start: …….. End …….	Time/s to be taken	Dosage	Method (e.g. topical, oral, injected)	Supervision required? ☐ No – self managed by student ☐ Yes ☐ Remind ☐ Observe ☐ Assist ☐ Administer

Medication taken to / stored at the school – Storage requirements

Indicate if there are any specific storage instructions for any of the required medications:

Supervision required

Students in the early years will generally need supervision of their medication and other aspects of health care management. In line with their age and stage of development and capabilities, older students can take responsibility for their own health care. Self-management should be agreed to by the student and their parents/carers, the school and the student's medical/health practitioner.

Please describe whether supervision or assistance is required by the student when taking medication at school (e.g. remind, observe, assist or administer):

Please indicate if permission is provided for the student to carry their medication (that does not have special storage requirements):

Authorisation to administer medication in accordance with this form			
Parent/Guardian/Carer 1 Name		Parent/Guardian/Carer 2 Name	
Signature		Signature	
Date		Date	
Please have an AHPRA registered medical practitioner or pharmacist complete the following section for ongoing use of prescription and/or over the counter medication			
Practitioner name			
Name of health practice			
Address			
Telephone		Email	
AHPRA registration number		Patient URL number	
Signature		Date	

Privacy statement

We collect personal and health information to plan for and support the health care needs of our students. Information collected will be used and disclosed in accordance with Holy Trinity published Privacy Policy.

Approval authority	Director, Learning and Regional Services
Approval date	17 August 2023
Next review	April 2025