SPRING GULLY PRIMARY SCHOOL
MEDICATION AUTHORITY FORM

For students requiring medication to be administered at school

Student Details

Name of student:_____ **Date of Birth:** _____

Grade and Teacher:_____

MedicAlert Number (if relevant): _____

Medication to be administered at school:

Name of Medication: _____

Dosage: _____

Time/s to be taken: _____

Storage Instructions: _____

Dates to be administered **Start Date:**_____ **End date:**_____

Medication delivered to the school

Please ensure that medication delivered to the school:

- ☐ Is in its original package
- ☐ The pharmacy label matches the information included in this form

Monitoring effects of medication

Please note: School staff ***do not*** monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

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 the Department of Education and Training's privacy policy which applies to all government schools (available at: http://www.education.vic.gov.au/Pages/schoolsprivacypolicy.aspx) and the law.

Authorisation to administer medication in accordance with this form:

Name of parent/carer: _____

Contact details: _____

Signature: _____Date: _____