

Medication Authority Form



This form is updated as required to reflect details of medication to be administered at school and should be read in association with the student's Medical Management Plan.

Student Details

| | |
|------------------------------------|---------------|
| Name of Student | Date of Birth |
| Date of Medical Management Plan | |
| MedicAlert Number (if applicable) | |
| Date for Medication Authority Form | |

Medication(s) to be administered at school

| Name of Medication | Dosage (amount) | Time/s to be taken | How is it to be taken? (e.g. oral/topical/ injection) | Dates to be administered | Supervision required? |
|--------------------|-----------------|--------------------|---|--|--|
| | | | | Start: End: OR <input type="checkbox"/> Ongoing medication | <input type="checkbox"/> No student self-managing <input type="checkbox"/> Yes <input type="checkbox"/> remind <input type="checkbox"/> observe <input type="checkbox"/> assist <input type="checkbox"/> administer |
| | | | | Start: End: <input type="checkbox"/> Ongoing Medication | <input type="checkbox"/> No Student Self-managing <input type="checkbox"/> Yes <input type="checkbox"/> Remind <input type="checkbox"/> Observe <input type="checkbox"/> Assist <input type="checkbox"/> Administer |
| | | | | Start: End: <input type="checkbox"/> Ongoing Medication | <input type="checkbox"/> No Student Self-managing <input type="checkbox"/> Yes <input type="checkbox"/> Remind <input type="checkbox"/> Observe <input type="checkbox"/> Assist <input type="checkbox"/> Administer |

Medication taken to/stored at the school

Indicate if there are any specific storage instructions for any medication:

Ensure that medication taken to the school is in its original package with original labels. Please note School staff will seek emergency medical assistance if concerned about a student's condition following medication.

Please outline the reasons the administration of medication is required. This should be supported by a Medical Management Plan for ongoing medical conditions or letter from the child's treating health practitioner:

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 [insert school name] published Privacy Policy.

Authorisation to administer medication in accordance with this form

Name of authorised parent/guardian/carer:

| | |
|-------------|-------------|
| Parent Name | Parent Name |
| Signature | Signature |

| | |
|--------------------------|--------------------|
| Date | Date |
| Health practitioner name | |
| Practice Name | |
| Contact details | |
| Telephone | Email |
| AHPRA Registration | Patient URL Number |
| Date | |