

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.

Today's Date: _____ Date of Medical Management Plan (if applicable): _____

Name of Student: _____ Class: _____ Date of Birth: _____

Parent / Guardian's Name: _____ Contact Number: _____

Treating Doctor / Practitioner's Name: _____ Contact Number: _____

Treating Doctor / Practitioner's Email Address: _____

Treating Doctor / Practitioner's Signature: _____

Reason for 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:* _____

Important Notes:

- Wherever possible, medication should be scheduled outside the school hours e.g. medication required three times a day is generally not required during a school day, it can be taken before and after school and before bed.
- Staff members are not permitted to administer the first dose of a new medication in the event that it may cause an adverse reaction. The first dose of all medication must be administered by a parent / guardian or medical practitioner.
- The school will not administer Paracetamol without the completion of this form as it may mask signs and symptoms of other illness or injury.

MEDICATION* separate form required for each medication				
Name of Medication	Dosage (Amount)	How is it to be taken? e.g. orally, inhaled, topical, injection.	Time/s to be taken	Date/s
				Start date: End Date: Or <input type="checkbox"/> Ongoing Medication
This Medication has been delivered to the school:		<input type="checkbox"/> In its original package <input type="checkbox"/> The pharmacy label matches the information included in this form		
Please indicate if there are specific storage instructions for the medication:		<input type="checkbox"/> Refrigerator <input type="checkbox"/> At room temperature		

SELF-ADMINISTRATION OF MEDICATION

The School discourages the self-administration of any medication and will only grant permission upon written authority from the Treating Medical Practitioner. Ideally, all self-administered medication should be stored by the school. N.B. This is not required for students with Asthma or Anaphylaxis as this is covered under ASCIA Action Plan for Anaphylaxis and the Asthma Foundation's School Asthma Action Plan.

COMPLETION OF ADMINISTRATION

At the completion of the school's agreement to administer medication, any residual medication & all empty containers / packets must be collected by the Parent / Guardian at their earliest convenience. The school may dispose of empty containers / packets only upon verbal authorisation from the Parent / Guardian.

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 the administration of medication.

PRIVACY STATEMENT

The school collects personal information to assist with the planning and support of the health care needs of the student. Without the provision of this information the quality of the health support provided may be affected. The information listed in this form may be disclosed to relevant School Staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by law. By signing below I hereby authorise staff at Queen of Peace Parish Primary School to administer medication to my child in accordance with the information provided above. I also give permission for the school to contact the Treating Medical Practitioner listed above if confirmation or further information about the administration of medication is required.

Parent / Guardian's Name: _____ Signature: _____

Student Medication Record (office use only)

Staff Members are required to complete this *Medication Record* after administering medication in accordance with the **Medical Authorisation Form** on reverse. This Medication Record will be kept in the student's file for future reference.

Day	Date	Time	Medication	Dosage	Administered By	Signature