

Authorisation for the Administration of Medication at School

This form is to be used when a student requires administration of medication during school hours where the medication is not covered under a medical action plan.

This form

- a. Provides authorisation for the school to administer medication to your child.
- b. Provides parental/guardian permission for your child to self-administer medication.
- c. Provides medical approval for your child to self-administer medication. Section B must be completed by a doctor, dentist, optometrist, the pharmacist dispensing the medication or a practice nurse from the prescribing doctor's surgery.

SECTION A: Medication instructions -	To be completed by par	ent or guardian			
Student's Details					
Surname or Family Name:	Given Name:	Date of Birth: Grade:			
Medication Details:		Self-Administration:			
Name of Medication:		Is the student permitted to self-administer this medication? Yes ● No ●			
Type of Medication (e.g. S8, S4d):		If yes , a medical practitioner must complete Section B over page. Your child will not be permitted to self-administer medication if Section B is not completed.			
Expiry Date:		If no and/or Section B is not completed , a staff member will administer the medication.			
Storage instructions (e.g. refrigerate, st	ore out of light etc.):				
Dose and route (e.g. by mouth, by injection	ction):				
Frequency:					
Relationship to meals or n/a (e.g. with food, before food):		Note : All medication must be supplied in the original container /packaging. All medications for short term use will be stored in a secure location and are not to be held by the student.			
Side effects, if any, which school staff should be made aware of:					
Parent/Guardian's Signature:					
_					
Parent/Guardian name (please print): _					
Address:					
Signature:					
Date:					

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SECTION B: To be completed by medical professional									
	_(Name) of		(Business name)						
	(Studen	t name) is capa	ble of self-administering the medication						
	Date:/		Phone:						
Please circle relevant profession :									
Dentist	Practice Nurse	Other, pleas	e specify						
	on:	(Name) of(Student	(Name) of (Student name) is capa Date:/						

Important: Please notify school immediately of any changes to the details above.

Record of Administration of Medication

Dosage	Time	Date	Person administering	Signature

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