



**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**  Ongoing medication | No student self-  managing  Yes  remind  observe  assist  administer |
|  |  |  |  | Start:  End:  Ongoing  Medication | No Student Self-managing  Yes  Remind  Observe  Assist  Administer |
|  |  |  |  | Start:  End:  Ongoing  Medication | No Student Self-managing  Yes  Remind  Observe  Assist  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 |  |