MEDICATION AUTHORITY FORM

COPIES OF THIS FORM ARE AVAILABLE FROM THE FRONT OFFICE

This form should be completed by the student's medical/health practitioner, for all medication to be administered at school. Medication is to be given to the first aid officer.

Students Name: ________________________________ Date of Birth: _________________

Allergy: ______________________________________ Review Date: _________________

Please Note: 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.

Name of Medication/s and purpose **eg Panadol tablet for teeth pain**	**Dosage (amount)**	**Time/s to be taken**	**How is it to be taken? eg orally, inhaled, topical**	**Dates**
				Start date: / / End date: / / Ongoing medication
				Start date: / / End date: / / Ongoing medication
				Start date: / / End date: / / Ongoing medication
Please indicate if there are specific storage instructions for any of the above medications:				

Please ensure that medication delivered to the school:

- **Is in its original packaging**
- **Has a pharmacy label matching the information on this form.**

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

Authorisation:

Medical/health practitioner Authority:	**Parent/Caregiver:**
Name:	**I have read, understood and agreed with this plan. I approve the release of this information to supervising staff and emergency medical personnel.**
Professional Role:	Parent/caregiver:
Date:	Signature:
Contact Details:	Date:

If additional advice is required, please attach it to this form.