Medication Authority Form

For students requiring medication to be administered at school.

1. This form must be signed by the student’s medical/health practitioner for all medication to be administered at school.

* **For students with asthma**, complete an Action Plan for Anaphylaxis.
* **For students with anaphylaxis**, complete an Action Plan for Asthma.

1. Please only complete the sections below that are relevant to the student’s health support needs. If additional advice is required, please attach it to this form.

Please note: wherever possible, medication should be scheduled outside school hours e.g. medication required three times daily is generally not required during a school day – it can be taken before and after school and before bed. Please consult your medical practitioner for advice on whether medication prescribed can be taken outside of school hours.

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| Student Details |

1. Name of school: Advanced education school\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name of student:\_\_\_\_\_Julian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:14/04/2019
3. Medicin Alert Number (if relevant): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Review date for this form: 23/ 5/2024

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| Medication to be Administered at School | | | | | |
| 1. **Name of Medication** | 1. **Dosage**   (amount) | 1. **Time/s to be taken** | 1. **How is it to be taken?**   (e.g. oral/topical/injection) | 1. **Dates to be administered** | 1. **Supervision required** |
| **Asthma** | **5ml** | **After lunch** | **injection** | 1. Start: / / 2. End: / / 3. **OR**   Ongoing medication | No   1. Student self-managing?   Yes:  remind  observe  assist  administer |
|  |  |  |  | 1. Start: / / 2. End: / / 3. **OR**   Ongoing medication | No   1. Student self-managing?   Yes:  remind  observe  assist  administer |

1. Please indicate if there are any specific storage instructions for any medication:
2. \_\_\_\_\_yes after taking medication keep it in a fridge\_.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Medication Delivered to the School |

1. Please ensure that medication delivered to the school:

Is in its original package

The pharmacy label matches the information included in this form

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| Supervision Required |

1. Students in the early years will generally need supervision of their medication and other aspects of health care management. In line with their age and stage of development and capabilities, older students can take responsibility for their own health care. Self-management should be agreed to by the student and their parents/carers, the school and the student’s medical/health practitioner.
2. Please describe what supervision or assistance is required by the student when taking medication at school (e.g. remind, observe, assist or administer):

\_\_\_\_Administer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Monitoring Effects of Medication |

1. 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.

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| Privacy Statement |

1. 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 the Department of Education and Training’s privacy policy which applies to all government schools.

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| Authorisation to Administer Medication in Accordance with this Form |

1. Name of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_Julian Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­
2. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_23\_ / \_05\_\_ / \_2024\_\_

Name of medical/health practitioner:\_\_\_\_Asthama\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

1. Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_