  


**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 be 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:

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# 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 |  |