Medication Authority Form

Student's Name:_____Date of Birth:_____

Class: _____

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.

Medication required:

Name of Medication/s	Reason	Dosage (amount)	Time/s to be taken	How is it to be taken? (eg orally/ topical)	Parental Approval prior to dose being given (Yes/No)	Dates
						Start date: / / End Date: / / □ Ongoing medication
						Start date: / / End Date: / / □ Ongoing medication
						Start date: / / End Date: / / □ Ongoing medication

Medication Storage

Please indicate if there are specific storage instructions for the medication:

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Medication delivered to the school

Please ensure that medication delivered to the school:

☐· Is in its original package

☐· The pharmacy label matches the information included in this form.

Monitoring effects of Medication

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.

Privacy Statement
The school collects personal information so as the school can plan and support the health care needs of the student. Without the provision of this information the quality of the health support provided may be affected. The information may be disclosed to relevant school staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by another law.

Authorisation:
Name of Parent/Carer:
Signature: Date:

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