MEDICATION AUTHORITY FORM

For students requiring medication to be administered at school

- **For students with asthma**, Asthma Australia's *School Asthma Care Plan*
- **For students with anaphylaxis**, an ASCIA Action Plan for Anaphylaxis

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, eg medication required three times daily is generally not required during a school day – it can be taken before and after school and before bed.

Student Details

Name of school: _____

Name of student:_____**Date of Birth:** _____

Medication to be administered at school:

Name of Medication	Dosage (amount)	Time/s to be taken	How is it to be taken? (eg oral/topical/injection)	Dates to be administered
				Start: / / End: / / **OR** ☐Ongoing medication
				Start: / / End: / / **OR** ☐Ongoing medication
				Start: / / End: / / **OR** ☐Ongoing medication

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

Please turn over and complete next page.

_____

_____

_____

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

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 (available at: http://www.education.vic.gov.au/Pages/schoolsprivacypolicy.aspx) and the law.

Authorisation to administer medication in accordance with this form:

Name of parent/carer: _____

Signature: _____Date: _____

Name of medical/health practitioner:_____

Professional role:_____

Signature:_____Date:_____

Contact details:_____