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AT SCHOOL
Medication Authority Form

CONFIDENTIAL

To be completed by the PARENT/GUARDIAN.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child:_____ _____
Family name (please print) First name (please print) Date of birth

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Please:

- *Complete all sections of this form.*
- *Schedule medication outside school hours wherever possible.*
- *Be specific: **As needed** is **not** sufficient direction—we need to know exactly when and how much*

Please note that staff:

- *Accept only medication which has been ordered by a doctor and/or is provided in the original, fully labeled pharmacy container*
- *Do not monitor the effects of medication as they have no training to do this*
- *Are instructed to seek emergency medical assistance if concerned about a person's behavior following medication.*

MEDICATION INSTRUCTIONS *(please print clearly)*		**TIME** *please tick administration time(s)*
Medication name *(include generic name)*		☐ 9 am – 10.00 am
Form *(eg liquid, tablet, capsule, cream)*	Route *(eg oral, inhaled, topical)*	☐ 10.00 – 11.00 am
	Dose	☐ 11.00 – 12 noon
Other instructions for administration such as storage		☐ 12 noon – 1.00 pm
Start/finish date *(if appropriate)* *from* *to*		☐ 1.00 pm – 2.00 pm ☐ 2.00 pm – 3.15 pm

AUTHORISATION AND RELEASE

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

_____
Family name (please print) First name (please print)

_____ _____
Signature Date