Medication Authority

This form should be completed ideally by the student's medical/health practitioner, for all medication to be administered at school. For those students with Asthma, an Asthma Foundation's *School Asthma Action Plan* should be completed instead. For those students with anaphylaxis, an ASCIA *Action Plan for Anaphylaxis* should be completed instead.

Please only complete those sections in this form which are relevant to the student's health support needs.

Name of School: Essex Heights Primary School

Student's Name: **Date of Birth:**

Medic-Alert Number (if relevant): **Review Date for this form:**

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	Dosage (amount)	Time/s to be taken	How is it to be taken? (e.g. orally/topical/injection)	Dates
				Start Date:
				End Date:
				Ongoing: ☐
				Start Date:
				End Date:
				Ongoing: ☐

MEDICATION STORAGE

Please indicate if there are specific storage instructions for the medication

MEDICATION DELIVERED TO THE SCHOOL

Please ensure that medication delivered to the school:

☐ Is in it's original packaging
☐ 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.

MEDICAL/HEALTH PRACTITIONER AUTHORISATION

Name of Medical/Health Practitioner:	
Contact Details:	
Signature:	Date:

PARENT/GUARDIAN/CARER AUTHORISATION

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

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