**Medication Authority Form**

This form is updated as required to reflect details of medication to be administrated at school and should be read in association with the student’s Medical Management Plan.

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| **Student Details** | | | | | | | |
| Students name: | |  | | | | | |
| Date of Birth: | |  | | MedicAlert Number  (if applicable): | |  | |
| Date for Medication  Authority Form: | |  | | Date of Medical  Management Plans: | |  | |
| School Name and location: | |  | | | | | |
| **Medication (s) to be administrated 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 administrated | | Supervision required |
|  |  | |  |  | Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  End: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Or  Ongoing medications | | No student self- managing  Yes  Remind  Observe  Assist  Administer |
| Name of Medication | Dosage (amount) | | Time/s to be taken | How is it to be taken? (e.g. oral/topical/injection) | Dates to be administrated | | Supervision required |
|  |  | |  |  | Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  End: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Or  Ongoing medications | | No student self- managing  Yes  Remind  Observe  Assist  Administer |
|  |  | |  |  | Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  End: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Or  Ongoing medications | | No student self- managing  Yes  Remind  Observe  Assist  Administer |
| **Medication taken to/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.* | | | | | | | |
| **Medication taken to/stored at the school** | | | | | | | |
| 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. | | | | | | | |
| **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 St James Primary School published Privacy Policy.

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| **Authorisation to administration medication in accordance with this form** | | | |
| Name of authorised parent/guardian/carer: | | | |
| Parent/Guardian/Carer Name: |  | Parent/Guardian/Carer Name: |  | |
| Signature: |  | Signature: |  | |
| Date: |  | Date: |  | |
| Health practitioner name: |  | | | |
| Practice names: |  | | | |
| Contact details: |  | | | |
| Telephone: |  | Email: |  | |
| AHPRA registration: |  | Patient URL number: |  | |
| Date: |  |  | | |