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: _____

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: ☐
				End Date:
				Ongoing: ☐

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

MEDICATION DELIVERED TO THE SCHOOL

AUTHORISATION	
Name of Medical/Health Practitioner:	
Professional Role:	
Signature:	
Date:	
Contact Details:	

PARENT/CARER OR ADULT/INDEPENDENT STUDENT** AUTHORISATION	
Name of Parent/Carer or adult/independent student**:	
Signature:	
Date:	

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

****Please note:** Adult student is a student who is eighteen years of age and older. Independent student is a student under the age of eighteen years and living separately and independently from parents/guardians