

Administration of Medication Authorisation Form A (Parent/Guardian)

Department of
Education

Use this form to provide authorisation to the school to

- a.) administer **non-prescribed** medication to your child
- b.) administer **prescribed** medication to your child .(To authorise the school to allow your child to self-medicate, you must **also** arrange for a doctor, or the pharmacist dispensing the medication or a practice nurse from the prescribing doctor's surgery to complete the form "Administration of Prescribed Medication Authorisation Form B (Doctor/Pharmacist/Practice Nurse)
- c.) allow your child to self-administer their prescribed medication.

Student's Name	Surname or family name _____ First given name Second given name _____
Medication to be given to student during school hours, as prescribed/authorised by the student's medical practitioner/pharmacist/practice nurse.	Name of medication _____ Expiry date _____ Dose and route (eg by mouth, by injection) _____ Frequency _____ Relation to meals or n/a _____ Side effects, if any, school staff should be made aware of _____ Medication has been supplied in original container with the instructions provided by the pharmacist. Yes/No Is the student permitted to self-administer this medication? Yes/No
Parent/Guardian's signature	Parent/Guardian name (please print) Address Signature: _____ Date: _____

Important: Please notify school immediately of any changes to the details above.

Administration of Prescribed Medication Authorisation Form B (Doctor/Pharmacist/Practice Nurse)

Department of
Education

- Use this form to provide authorisation to the school to
 - a.) administer prescribed medication to the child named on the form
 - b.) allow the child named on the form to self-administer prescribed medication.
- This form must be completed either by a doctor, or the pharmacist dispensing the medication or a practice nurse from the prescribing doctor's surgery.
- Please complete the appropriate sections.

Student's Name	Surname or family name First given name Second given name _____
Oral medication to be given to student during school hours.	Name of medication _____ Type of medication (eg S8, S4d) _____ Dose and route _____ Frequency _____ Relation to meals or n/a _____ Side effects, if any, school staff should be made aware of _____ Is the student permitted to self-administer this medication? Yes/No
EpiPen treatment to be given to student when sign/symptoms occur during school hours after known or suspected exposure.	Student has severe allergic reaction to: _____ Allergic reaction is a result of the student being exposed to: _____ The following signs/symptoms result from exposure: _____ Name of staff member/s to administer medication: _____ Name of medication _____ Expiry date _____ Dosage and route _____ Frequency _____
Signature Please circle relevant profession: Doctor Pharmacist Practice Nurse	Name (please print) Address Signature: _____ Date: _____

Important: Please notify school immediately of any changes to the details above. Doc ID: TASED-4-1205