MEDICATION AUTHORITY FORM

oberon south
PRIMARY SCHOOL

This form should be completed for all medication to be administered by the school. In the instance of long term medication this ideally would be completed by the student's medical/health practitioner.
For students with Asthma an Asthma Action Plan should be completed instead.
For students with Diabetes a Diabetes Care Plan should be completed instead.
For students with Anaphylaxis a ASCIA Action Plan for Anaphylaxis should be completed instead.

Please complete those sections only relevant.

Students Name	
Date of Birth	
Review Date	

MEDICATION REQUIRED				
Name of Medication	**Dosage (amount)**	**Time/s to be taken**	**How is it to be taken**	**Dates**
				Start Date: **End Date:** **Ongoing** ☐
				Start Date: **End Date:** **Ongoing** ☐
				Start Date: **End Date:** **Ongoing** ☐
MEDICATION STORAGE				
Please indicate if there are specific store instructions for this medication				

Please ensure that medication delivered to the school:

☐ In its original package
☐ The pharmacy label matches the information included in this form

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.

PRIVACY STATEMENT

The school collects personal information so as the school can plan and support the health care needs of the student. Without the provision of this information the quality if the health support provided may be affected. The information may be disclosed to relevant scho0ol staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate or where authorised or required by another law. You are able to request access to the personal information that we hold about you/your child and to request that it be corrected. Please contact the school directly or the Freedom of Information Unit on (03) 9637 2670. http://www.education.vic.gov.au/about/contact/Pages/foi.aspx

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

PARENT/CARER AUTHORISATION	
Name of Parent/Carer	
Signature	
Date	
Contact Details	

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

Medication Administration

STUDENT NAME:_____
DOSAGE: _____

Date:	Time:	Administered by: