Medication Authority and Administration Form

Section A: Authorisation and Medication Details			
Child's Name		**Date of Birth**	/ /
Parent/Carer Name		**Phone Number**	
Name of medication to be administered			
Dosage of medication to be administered			
Method (e.g., oral) medication to be administered			
Any additional instructions or information (i.e., medication required to be refrigerated)			
NOTE: This form only collects information for one (1) medication. If more than one medication is required, please complete a separate form for each medication.			

- ☐ I consent to the following medication being administered (as per the instructions on the pharmacy label and/or any additional written instructions) to the child named above during school or school-related activities.

I confirm that the medication provided to EPOSHC (as listed above):

- ☐ is medically authorised (e.g. has been prescribed by a doctor, dentist, optometrist or nurse practitioner)
- ☐ is in the original dispensed container with intact packaging or,
- ☐ if the medication needs to be in a small dosage (less than the whole amount in the package), it is in a Webster or properly packaged and cracked by the pharmacy, and labelled accordingly
- ☐ has the child's and doctor's names on the pharmacy label (if there is no other written evidence of medical authorisation)
- ☐ is current/in-date (The expiry date of the medication is _ _ / _ _ / _ _ _ _).

The medication is required:	**If Yes to any questions, complete the following:**	
(a) routinely (e.g. 11am every day)	☐ No ☐ Yes⇨	Administer at _ _: _ _ am/pm on the following days: *(circle the day/s required)* Monday Tuesday Wednesday Thursday Friday
(b) for a short time only (e.g. only for 2 weeks)	☐ No ☐ Yes⇨	Start date: _ _/_ _/_ _ _ _ End date: _ _/_ _/_ _ _ _
(c) to manage a health condition by following a current action plan or health plan	☐ No ☐ Yes⇨	Is the medication for: ☐ asthma ☐ anaphylaxis ☐ diabetes ☐ epilepsy ☐ cystic fibrosis ☐ ADHD/ASD ☐ infections ☐ other *(describe)* ________________

(d) 'as needed' to treat minor or non-emergency symptoms	☐ No ☐ Yes⇨	☐ I understand that before EPOSHC administers this medication, if they are not aware of when this medication was most recently given to this child, I will be contacted to provide this information.

Has this child previously shown any side effects after taking this medication?	☐ No ☐ Yes
If Yes, describe: ____	

Parent/carer/student signature		Date	

If the student is to self-administer this medication, also complete **Section B**

NOTE: Controlled medications cannot be self-administered. If the student is to self-administer this medication, also complete **Section B**

Section B: Details for child self-administration of medication:			
In all cases and at any time, the child's self-administration of medication will be witnessed by two educators.			
Child's Name		**Date of birth**	

☐ I confirm that the child is confident, competent and can safely administer the right dose of their own medication at the right times.
☐ I confirm that the child can store their medication securely.

Health condition	
☐ Asthma - secondary school students only	☐ I approve for the child to self-administer their asthma medication. **NOTE:** EPOSHC will need a copy of the student's Asthma Action Plan if it varies from the standard asthma first aid response
Health condition	I seek approval from the Nominated Supervisor/Delegate for the child to self-administer:
☐ Asthma	☐ their asthma medication (following a current action plan/health plan)
☐ Anaphylaxis	☐ their adrenaline auto-injector (following a current action plan/health plan)
☐ Diabetes	☐ their medication (following a current health plan)
☐ Other ____________________	☐ their medication (following a current health plan)

Parent/carer/student signature		Date	

EPOSHC