Catholic Education Tasmania

Authorisation for the Administration of Medication at School

This form is to be used when a student requires administration of medication during school hours where the medication is not covered under a medical action plan.

This form

a. Provides authorisation for the school to administer medication to your child.
b. Provides parental/guardian permission for your child to self-administer medication.
c. Provides medical approval for your child to self-administer medication. Section B must be completed by a doctor, dentist, optometrist, the pharmacist dispensing the medication or a practice nurse from the prescribing doctor's surgery.

SECTION A: Medication instructions - To be completed by parent or guardian

Student's Details

Surname or Family Name: _____ Given Name: _____ Date of Birth: _____ Grade: _____

Medication Details:

Name of Medication: _____

Type of Medication (e.g. S8, S4d): _____

Expiry Date: _____

Storage instructions (e.g. refrigerate, store out of light etc.): _____

Dose and route (e.g. by mouth, by injection): _____

Frequency: _____

Relationship to meals or n/a (e.g. with food, before food): _____

Side effects, if any, which school staff should be made aware of: _____

Self-Administration:

Is the student permitted to self-administer this medication?
Yes • No •

If **yes**, a medical practitioner **must** complete Section B over page. Your child will not be permitted to self-administer medication if Section B is not completed.

If **no** and/or **Section B is not completed**, a staff member will administer the medication.

Note: All medication must be supplied in the original container /packaging. All medications for short term use will be stored in a secure location and are not to be held by the student.

Parent/Guardian's Signature:

Parent/Guardian name (please print): _____

Address: _____

Signature: _____

Date: _____

SECTION B: To be completed by medical professional

I _____(Name) of _____ (Business name)

certify that _____ (Student name) is capable of self-administering the medication listed above.

Signature: _____ Date: ____/____/_____ Phone: _____

Please circle relevant profession:

Doctor **Pharmacist** **Dentist** **Practice Nurse** **Other, please specify** _____

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

Record of Administration of Medication

Dosage	Time	Date	Person administering - Name & Signature	Witness - Name & Signature