Authorisation for Administration of Student Medication

Form A: Non-prescription – to be completed by parent/carer

Student name: _____ Date of birth: _____

School: _____ Year level: _____

Non-prescribed medication to be given to student during school hours (please print additional copies of this form if more space is needed)

Name of medication (please ensure brand/generic name matches medication label)	Dose	Route (mouth, nasal spray etc.)	Frequency or time	Relation to meals or N/A	In original container?*	Student permitted to self-administer?
					Yes / No	Yes / No
					Yes / No	Yes / No
					Yes / No	Yes / No
					Yes / No	Yes / No
					Yes / No	Yes / No

I understand that this form provides authorisation for administration, or self-administration (if indicated) of non-prescribed medication to the student named. I understand that I should notify the school **immediately** if this information changes. *I understand that all medication **must** be supplied in the original container or Webster-pak, and that the school cannot administer medication if it is not supplied in the original container or Webster-pak.

Parent/carer name: _____ Relationship to student: _____

Address: _____ Phone number/s: _____

Signature: _____ Date: _____

Personal information collected on this form is to be used to provide support services for your child. This will only be used for the primary purpose for which it is gathered, except where authorized or mandated by legislative requirements (e.g. Mandatory Reporting). For further information, contact Learning Services.

Authorisation for Administration of Student Medication

Form B: Prescription medication – to be completed by doctor/pharmacist/practice nurse (RN)

Student name: _____ Date of birth: _____

School: _____ Year level: _____

Prescribed medication to be given to student during school hours (please print additional copies of this form if more space is needed)

Name of medication (please ensure brand/generic name matches medication label)	Type of medication (e.g. Schedule 8, Schedule 4d)	Dose and route	Frequency or time	Relation to meals or N/A	Side effects if any	In original container?*	Student permitted to self-administer?
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No

I understand that this form provides authorisation for administration, or self-administration (if indicated) of prescribed medication to the student named. I understand that I should notify the school **immediately** if this information changes. *I understand that all medication must be supplied in the original container or Webster-pak, and that the school cannot administer medication if it is not supplied in the original container or Webster-pak.

Name: _____ Profession (circle): Doctor / pharmacist / practice nurse (RN)

Address: _____ Phone number/s: _____

Signature: _____ Date: _____ Parent/guardian signature: _____ Date: _____

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