Oxley Primary School

1050 Wangaratta-Whitfield Road
OXLEY VIC 3678
Phone: 03 5727 3312
Email: oxley.ps@edumail.vic.gov.au

MEDICATION AUTHORITY FORM

For students requiring medication to be administered at school

This form should, ideally, be signed by the student's medical/health practitioner for all medication to be administered at school but schools may proceed on the signed authority of parents in the absence of a signature from a medical practitioner.

- **For students with asthma**, Asthma Australia's *School Asthma Care Plan*
- **For students with anaphylaxis**, an ASCIA Action Plan for Anaphylaxis

Please only complete the sections below that are relevant to the student's health support needs. If additional advice is required, please attach it to this form. **Please note: wherever possible, medication should be scheduled outside school hours, eg medication required three times daily is generally not required during a school day – it can be taken before and after school and before bed.**

Student Details

Name of student: ______________________________ **Date of Birth:** ________ / ________/ ________

Weight if applicable: ________ **kg** **MedicAlert Number (if relevant):** ______________________________

Review date for this form: ________ / ________/ ________

Medication to be administered at school:

Name of Medication	Dosage	Time/s to be taken	How is it to be taken? (eg oral/topical/injection)	Storage of medication	Dates to be administered	Supervision required
					Start: / / End: / / **OR** ☐Ongoing medication	☐ No – student self- managing ☐ Yes ☐ remind ☐ observe ☐ assist ☐ administer
					Start: / / End: / / **OR** ☐Ongoing medication	☐ No – student self- managing ☐ Yes ☐ remind ☐ observe ☐ assist ☐ administer

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Authorisation to administer medication in accordance with this form:

Name of parent/carer: ______________________________ Signature: ______________________________

Date: _________ / _________/ _________

Name of medical/health practitioner:______________________________ Contact details:______________________________

Professional role:______________________________ Signature:______________________________

Date: _________ / _________/ _________

Medication delivered to the school

Please ensure that medication delivered to the school:

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

Supervision required

Please describe what supervision or assistance is required by the student when taking medication at school:

☐ Self Administration with observation of staff member ☐ Administer by staff member ☐ Reminder required

Further instruction: ____

Monitoring effects of medication

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

We collect personal and health information to plan for and support the health care needs of our students. Information collected will be used and disclosed in accordance with the Department of Education and Training's privacy policy which applies to all government schools (available at: http://www.education.vic.gov.au/Pages/schoolsprivacypolicy.aspx) and the law.