WANDIN NORTH PRIMARY SCHOOL

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.

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, e.g 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:____

Class /Teacher: ________________________________**Date**___________

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.

MEDICATION DELIVERED TO SCHOOL

Please indicate if there are any specific storage instructions for any medication

Please ensure that all medication delivered to the school:

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

SUPERVISION REQUIRED

Students in the early years will generally need supervision of their medication and other aspects of health care management. In line with their age and stage of development and capabilities, older students can take responsibility for their own health care. Self-management should be agreed to by the student and their parents/carers, the school and the student's medical/health practitioner.
Please describe what supervision or assistance is required by the student when taking medication at school (e.g. remind, observe, assist or administer):

PTO:::: PLEASE SIGN AND FILL IN BACK OF FORM

Name of student ______________________________________ Date ______________

Name of Medication	Dosage (amount)	Time /s to be taken	How is it to be taken? orally/topical	Dates to be administered
				Start: ____/____/ End: ____/____/
				Start: ____/____/ End: ____/____/

RECORD OF ADMINISTERING

Name of Medication	Dosage (amount)	Time /s to be taken lunch	How is it to be taken? orally/topical	Date	Signed by	Witnessed

Name of parent/carer: ____

Signature: ____________________________________Date: __________________

MONITORING EFFECTS OF MEDICATION

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