Beaconsfield
PRIMARY SCHOOL 1890

Medication Authority Form

For a student who requires medication whilst at school

This form should be completed ideally by the student's medical/health practitioner, for all medication to be administered at school. For those students with asthma, an Asthma Foundation's *School Asthma Action Plan* should be completed instead. For those students with anaphylaxis, an ASCIA *Action Plan for Anaphylaxis* should be completed instead. Please only complete those sections in this form which are relevant to the student's health support needs. These forms are available from: DET Health Support Planning Policy

Name of School: _____

Student's Name: _____ Grade: _____ Date of Birth: _____

Medic-Alert Number (if relevant): _____ Review date for this form: _____

Please Note: wherever possible, medication should be scheduled outside the school hours, e.g. medication required three times a day is generally not required during a school day: it can be taken before and after school and before bed.

MEDICATION REQUIRED				
Name of Medication/s	**Dosage (amount)**	**Time/s to be taken**	**How is it to be taken? (e.g. orally/topical/injection)**	**Dates**
				Start Date:
				End Date:
				Ongoing: ☐
				Start Date:
				End Date:
				Ongoing: ☐
				Start Date:
				End Date:
				Ongoing: ☐

Medical Practitioner please cross out excess lines and initial: _____

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MEDICATION STORAGE
Please indicate if there are specific storage instructions for the medication:

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

SELF-MANAGEMENT OF MEDICATION
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 follow agreement by the student and his or her parents/carers, the school and the student's medical/health practitioner. Please advise if this person's condition creates any difficulties with self-management, for example, difficulty remembering to take medication at a specified time or difficulties coordinating equipment:

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

The school collects personal information so as the school can plan and support the health care needs of the student. Without the provision of this information the quality of the health support provided may be affected. The information may be disclosed to relevant school staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by another law. You are able to request access to the personal information that we hold about you/your child and to request that it be corrected.

AUTHORISATION	
Name of Medical/Health Practitioner:	
Professional Role:	
Signature:	
Date:	
Contact Details (Stamp):	