

MEDICAL AUTHORITY FORM

This form needs be completed by the student's medical/health practitioner for all prescription medication to be administered at school or on camps and excursions. Parents can complete this form for all non-prescription medication.

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

Please note: wherever possible, medication should be scheduled outside 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 (Please update these details on Operoo)

Name & Expiry Date of Medication	Dosage (Amount)	Time/s to be taken	How is it to be taken (e.g. orally/topical/injection/inhaled)	Dates
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No

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 College is in its original package with the pharmacy label that matches the information included in this form.

MONITORING EFFECTS OF MEDICATION

Please note College 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 College collects personal information so that the College 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 College 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

Doctor's Name (for prescribed medication only)	
Signature:	Date:
Parent/Carer's Name	
Signature:	Date:

Office Use Only	
Date Received	Actioned by:
Details on Operoo: YES NO	

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MEDICATION ADMINISTRATION LOG

Name of student: _____ Year level: _____

Date (Day, month and year)	Family Name (please print)	First Name (please print)				Name of First Staff (Please print and sign)	Name of Second Staff (please print and sign)
		Right Child	Tick Right Medication	Right Dose	Right Route (oral/inhaled) (✓)		