Medication Authority Form





This form is updated as required to reflect details of medication to be administered at school and should be read in association with the student's Medical Management Plan.

Student Details

Name of Student	Date of Birth
Date of Medical Management Plan	
MedicAlert Number (if applicable)	
Date for Medication Authority Form	

Medication(s) to be administered at school

Name of Medication	Dosage (amount)	Time/s to be taken	How is it to be taken? (e.g. oral/topical/injection)	Dates to be administered	Supervision required?
				Start: End: OR Ongoing medication	 No student selfmanaging Yes remind observe assist administer

				Start:	☐ No Student Self-
					managing
				End:	
					☐ Yes
				☐ Ongoing	☐ Remind
				Medication	☐ Observe
					☐ Assist
					☐ Administer
				Chambi	□ N = Ctd==t C=lf
				Start:	☐ No Student Self-
				End:	managing
				Liid.	☐ Yes
				☐ Ongoing	☐ Remind
				Medication	☐ Observe
					☐ Assist
					☐ Administer
	to/stored at the s				
			abels. Please note School sto	aff will seek emergency m	edical assistance if
concerned about a student	s's condition following medic	cation.			

conditions or letter from the child's treating health practitioner:					

Please outline the reasons the administration of medication is required. This should be supported by a Medical Management Plan for ongoing medical

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 [insert school name] published Privacy Policy.

Authorisation to administer medication in accordance with this form

Name of authorised parent/guardian/carer:

Parent Name	Parent Name
Signature	Signature
Date	Date
Health practitioner name	
Practice Name	
Contact details	
Telephone	Email
AHPRA Registration	Patient URL Number
Date	