St Margaret's Primary School

Medication Authority Form

It is preferred that the following form is completed in consultation with the student's treating medical practitioner. If this is not possible then this form must be completed by the student's parents or guardian in accordance with medical advice before any medication can be administered.

Name of Student: _____ Class:_____

Parent / Guardian's Name: _____ Contact Number:_____

Treating Practitioner's Name: _____ Contact Number:_____

Reason for Medication: _____

Recommended Restrictions on Participating in School Activities: _____

_____

Important Notes:

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.

Staff Members are not permitted to administer the first dose of a new medication in the event that it may cause an adverse reaction. The first dose of all medication must be administered by a parent / guardian or medical practitioner.

The school will not administer Paracetamol without the completion of this form as it may mask signs and symptoms of other illness or injury.

Medication Required:

Name of Medication/s	Dosage (Amount)	Time/s to be taken	How is it to be taken? (eg orally/inhaled topical/injection)	Dates
				Start date: / / **End Date: / /** **□ Ongoing Medication**
				Start date: / / **End Date: / /** **□ Ongoing Medication**

Please note: School staff do no monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behavior/reaction following the administration of medication.

Medication Storage:

(Please indicate if there are any specific storage instructions for the medication e.g. refrigeration)

_____

Authorisation:

By signing below I hereby authorise staff at St Margaret's School to administer medication to my child in accordance with the information provided above. I also give permission for the school to contact the Treating Medical Practitioner listed above if confirmation or further information about the administration of medication is required.

Parent / Guardian's Name:

Signature: Date:

Recording:

Date	Time	Dosage Amount	Administered By

Date	Time	Dosage Amount	Administered By