Medication authority

for education, childcare and community support services*

CONFIDENTIAL

To be completed by the AUTHORISED PRESCRIBER and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to relevant staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Allergies _____

Note: *Medication authorities can be endorsed by the following: medical practitioners (GPs and/or specialists), dentists, ophthalmologists, nurse practitioners, pharmacists*

Please:

- *Complete all sections of this form.* ***This is a single-medication sheet.*** *Please use a separate form for each medication.*
- *This medication form is appropriate for both* ***long term and short term*** *medication e.g. Antibiotics*
- *Schedule medication outside care/school hours wherever possible*
- *Be specific:* ***As needed*** *is* ***not*** *sufficient direction for staff — they need to know exactly when medication is required*
- *Nominate the simplest method.* ***For example: Oral or 'puffer' medication is easier to arrange than a nebuliser.***

Please note that education and child/care and community services workers:

- *accept only medication which has been ordered by an authorised prescriber and is provided in a fully labeled pharmacy container*
- *do not monitor the effects of medication as they have no training to do this*
- *are instructed to seek emergency medical assistance if concerned about a person's behavior following medication.*

MEDICATION INSTRUCTIONS *(please print clearly)*		**TIME** *please tick administration time(s)*
Medication name *(include generic name)*		☐ 07 – 08.30 am ☐ 09 – 10.30 am ☐ 11 – 12.30 am ☐ 01 – 02.30 pm ☐ 03 – 04.30 pm ☐ 05 – 06.30 pm ☐ 07 – 08.30 pm ☐ Overnight ☐ Other *(if medically necessary)* *Please specify:*
Form *(eg liquid, tablet, capsule, cream)*	Route *(eg oral, inhaled, topical)*	
Strength	Dose	
Other instructions for administration		
Start/finish date *(if appropriate)* *from* *to*		

The flexibility in times allows planning around activities

Please note:

- *Young children (eg junior primary age) are generally supervised when they take their oral/puffer medication*
- *Wherever possible, safe self-management is encouraged.*

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 (eg puffer and spacer).

_____

_____

This plan has been developed for the following services/settings: *

☐ School/education
☐ Child/care
☐ Respite/accommodation
☐ Transport
☐ Outings/camps/holidays/aquatics
☐ Work
☐ Home
☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Authorised prescriber _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)