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 ${\textit{Family name (please}}$		ate of birth	
MedicAlert Number (if relevant)	Date for next revi	iew	
Allergies			
Note: Medication authorities can be endorsed to ophthalmologists, nurse practitioners, pharmacist Please: Complete all sections of this form. This is a This medication form is appropriate for both Schedule medication outside care/school hou. Be specific: As needed is not sufficient dire Nominate the simplest method. For example Please note that education and child/care an accept only medication which has been order container do not monitor the effects of medication as the are instructed to seek emergency medical as	single-medication sheet. Please use a se, long term and short term medication e.g. urs wherever possible ection for staff — they need to know exactly ele: Oral or 'puffer' medication is easier to dommunity services workers: red by an authorised prescriber and is provide they have no training to do this	parate form for each medication. Antibiotics when medication is required to arrange than a nebuliser. ded in a fully labeled pharmacy vior 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 The	
Form (eg liquid, tablet, capsule, cream)	Route (eg oral, inhaled, topical)	☐ 11 – 12.30 am flexibility in times allows	
Strength	Dose	☐ 03 – 04.30 pm planning planning around	
Other instructions for administration	1	☐ 07 − 08.30 pm activities ☐ Overnight ☐ Other (if medically necessary)	
Start/finish date (if appropriate) from	to	Please specify:	
Please note: Young children (eg junior primary age) are g Wherever possible, safe self-management is Please advise if this person's condition creates a take medication at a specified time or difficulties	encouraged. In difficulties with self-management; for example of the self-management in the self-management in the self-management.	ample, difficulty remembering to	
This plan has been developed for the follow	wing services/settings: *		
School/educationChild/careRespite/accommodationTransport	 Outings/camps/holidays/aquatics Work Home Other (please specify) 		
AUTHORISATION AND RELEASE			
Authorised prescriber			
Address		phone	
	Telephone Date		
I have read, understood and agreed with this pla I approve the release of this information to supe	an and any attachments indicated above.		
Parent/guardian or adult student/client	Signature First name (please print)	Date	