# 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<br>☐ 09 – 10.30 am<br>☐ 11 – 12.30 am<br>☐ 01 – 02.30 pm<br>☐ 03 – 04.30 pm<br>☐ 05 – 06.30 pm<br>☐ 07 – 08.30 pm<br>☐ Overnight<br>☐ Other *(if medically necessary)*<br>*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).

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**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)