

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)

MediAlert 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 <i>(please print clearly)</i>		TIME <i>please tick administration time(s)</i>
Medication name <i>(include generic name)</i>		<input type="checkbox"/> 07 – 08.30 am <input type="checkbox"/> 09 – 10.30 am <input type="checkbox"/> 11 – 12.30 am <input type="checkbox"/> 01 – 02.30 pm <input type="checkbox"/> 03 – 04.30 pm <input type="checkbox"/> 05 – 06.30 pm <input type="checkbox"/> 07 – 08.30 pm <input type="checkbox"/> Overnight <input type="checkbox"/> Other <i>(if medically necessary)</i> <i>Please specify:</i>
Form <i>(eg liquid, tablet, capsule, cream)</i>	Route <i>(eg oral, inhaled, topical)</i>	
Strength	Dose	
Other instructions for administration		
Start/finish date <i>(if appropriate)</i> _____ 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: *

- | | |
|--|--|
| <input type="checkbox"/> School/education | <input type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care | <input type="checkbox"/> Work |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other <i>(please specify)</i> |

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)