

Medication authority

for education, child/care 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 supervising 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 _____

To the doctor (or other authorised prescriber)

Please:

- Complete all sections of this form.
- Schedule medication outside care/school hours wherever possible.
- Be specific: **As needed is not sufficient** direction for staff members—they need to know exactly when medication is required.
- Nominate the simplest method. **For example: Oral or 'puffer' medication is much 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 a doctor and is provided in the original, 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 | | |

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: * | |
|--|--|
| <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>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.</i> | |
| Parent/guardian or adult student/client _____ Signature _____ Date _____ | |
| <small>Family name (please print) First name (please print)</small> | |