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

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)