

Medication Authorisation Form

This form should be completed ideally by the student's medical/health practitioner, for all medication to be administered at school. If this is not possible, then this matter form must be completed by the student's parents or guardian in accordance with medical advice before any medication can be administered.

Please Note: wherever possible, medication should be scheduled outside the school hours, e.g. medication required three times a day is generally not required during a school day: it can be taken before & after school and before bed.

Full Name of Student			
Student Class & Colour		Student Date of Birth	

MEDICATION REQUIRED				
Name of Medication/s	Medication Dosage <small>(amount needed)</small>	Time/s Medication is Administered	How is Medication to be Administered <small>(orally, inhaled, injected etc.)</small>	Dates
				Start Date: / / End Date: / / Or Ongoing <input type="checkbox"/>
				Start Date: / / End Date: / / Or Ongoing <input type="checkbox"/>
				Start Date: / / End Date: / / Or Ongoing <input type="checkbox"/>

MEDICATION STORAGE
Please indicate if there are any specific storage instructions for the medication
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Medication delivered to Christ the Priest Catholic Primary School

Please ensure that medication delivered to Christ the Priest Catholic Primary School: -

- Is in its original package
- The Pharmacy label matches the information included in this form

Monitoring effects of Medication

Christ the Priest Catholic Primary School staff does not monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following the administration of medication.

Privacy Statement

Christ the Priest Catholic Primary School collects personal information to assist with the planning and support of the health care needs of the student. Without the provision of this information, the quality of the health support provided may be affected. The information listed in this form may be disclosed to relevant School Staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by law.

AUTHORISATION

Medical Practitioner

Medical Practitioner Name: _____

Surgery/Clinic: _____

Surgery/Clinic Telephone: _____

Signature: _____

Date: _____

Parent/Guardian

Parent/Guardian Name: _____ Contact Number: _____

Signature: _____

Date: _____