

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 <small>(please print clearly)</small>		TIME <small>please tick administration time(s)</small>
Medication name <small>(include generic name)</small>		<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 <small>(if medically necessary)</small> <small>Please specify:</small>
Form <small>(eg liquid, tablet, capsule, cream)</small>	Route <small>(eg oral, inhaled, topical)</small>	
Strength	Dose	
Other instructions for administration		
Start/finish date <small>(if appropriate)</small> 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).

This plan has been developed for the following services/settings: *	
<input type="checkbox"/> School/education <input type="checkbox"/> Child/care <input type="checkbox"/> Respite/accommodation <input type="checkbox"/> Transport	<input type="checkbox"/> Outings/camps/holidays/aquatics <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other <small>(please specify)</small>
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>	