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[ ]  11 – 12.30 am[ ]  01 – 02.30 pm[ ]  03 – 04.30 pm[ ]  05 – 06.30 pm[ ]  07 – 08.30 pm[ ]  Overnight[ ] Other *(if medically necessary)**Please specify:*      |
| Form *(eg liquid, tablet, capsule, cream)*       | Route *(eg oral, inhaled, topical)*      |  |
| Strength       | Dose      |  |
| Other instructions for administration       |  |
| Start/finish date *(if appropriate)*       *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: \*

[ ]  School/education [ ]  Outings/camps/holidays/aquatics

[ ]  Child/care [ ]  Work

[ ]  Respite/accommodation [ ]  Home

[ ]  Transport [ ]  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)