



This information is confidential and will be available only to relevant staff and emergency medical personnel.
*Medication Plans that are modified, overwritten or illegible will **NOT** be accepted.*

ATTENTION: PARENT/GUARDIAN

- Please complete all relevant sections authorising education and care staff to administer medication as instructed.
- All sections of the “Parent/Guardian Authorisation and Release” must be ticked to confirm acknowledgement of statements and authorisation to administer in an education setting.
- Medication to be delivered to school by the parent/guardian and is kept secure in the First Aid Room.

Student Name: _____	Class: _____	Date of Birth: ____/____/____
Condition(s) requiring medication: _____		
Allergies: _____		

MEDICATION INSTRUCTIONS

The medication instructions must match EXACTLY to the pharmacy label on the medication or the medication will not be administered.

MEDICATION NAME		STRENGTH (mg or mg/ml)
DOSE (the number of tablets or mls must be written)	ROUTE (oral, topical, inhaled)	TIMES TO BE ADMINISTERED (to be administered within ½ hour of specified time)
FORM (liquid, tablet, capsule, lotion, inhaler)		
OTHER INSTRUCTIONS (how to administer: i.e.: with food or crushed with water, etc)		
START DATE:	END DATE:	

PARENT/GUARDIAN AUTHORISATION AND RELEASE (Please tick all relevant boxes)

- The medications documented above are in **fully labelled pharmacy containers and have the child’s details that match the information on this form above.**
- The medication documented above is NOT a Controlled Drug (S8), oxygen, insulin or pain relief that requires administration for more than 72 continuous hours (if yes, a Medication Plan for Controlled Drugs (S8) must be completed separately).
- Where the medication is a prescription medication; the medication has been prescribed for a current health condition.
- I confirm these medications have been administered to my child previously (the first dose can NOT be administered in an education or care setting).
- My child is well enough for school (no active fever, no diarrhea or vomiting in the past 24 hours) and if there is a change in my child’s health condition I may be called to collect them.
- I approve the release of this information to supervising staff and emergency personnel (if required).
- I certify the above statements are true and correct, and confirm that I have read, understood and agreed with this plan and any attachments placed on the form above.
- I acknowledge that this Medication Plan must be renewed at the start of the school year or if there is a change.

Parent/Guardian Name: _____ **Signature:** _____ **Date:** ____/____/____