

# Medication authority

for education, childcare 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 relevant 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 \_\_\_\_\_

Allergies \_\_\_\_\_

**Note:** Medication authorities can be endorsed by the following: medical practitioners (GPs and/or specialists), dentists, ophthalmologists, nurse practitioners, pharmacists

**Please:**

- Complete all sections of this form. **This is a single-medication sheet.** Please use a separate form for each medication.
- This medication form is appropriate for both **long term and short term** medication e.g. Antibiotics
- Schedule medication outside care/school hours wherever possible
- Be specific: **As needed is not** sufficient direction for staff — they need to know exactly when medication is required ▪ Nominate the simplest method. **For example: Oral or 'puffer' medication is 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 an authorised prescriber and is provided in a 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)		<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 (if medically necessary) <input type="checkbox"/> Please specify: <input type="checkbox"/> <input type="checkbox"/>
Form (eg liquid, tablet, capsule, cream)	Route (eg oral, inhaled, topical)	
Strength	Dose	
Other instructions for administration		
Start/finish date (if appropriate)                      from                      to		

The flexibility in times allows planning around activities

**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: \***

- |  |                               |
|--|-------------------------------|
| <input type="checkbox"/> School/education      |                               |
| <input type="checkbox"/> Child/care            | Work <input type="checkbox"/> |
| <input type="checkbox"/> Respite/accommodation | Home <input type="checkbox"/> |
| <input type="checkbox"/> Transport             |                               |

**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/Caregiver

or adult student/client \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Family name (please print) First name (please print)