MEDICAL AUTHORITY FORM

This form needs be completed by the student's medical/health practitioner for all prescription medication to be administered at school or on camps and excursions. Parents can complete this form for all non-prescription medication.

Student's Name:_____Year:_____
Date of Birth:_____

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

MEDICATION REQUIRED (Please update these details on CareMonkey)

Name & Expiry Date of Medication	Dosage (Amount)	Time/s to be taken	How is it to be taken (e.g. orally/topical/injection/inhaled)	Dates
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No
Expiry Date / /				Start Date: End Date: Ongoing Medication Yes / No

MEDICATION STORAGE
Please indicate if there are specific storage instructions for the medication

_____

MEDICATION DELIVERED TO THE SCHOOL
Please ensure that medication delivered to the College is in its original package with the pharmacy label that matches the information included in this form.

MONITORING EFFECTS OF MEDICATION
Please note College staff *do not* monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

PRIVACY STATEMENT
The College collects personal information so that the College can plan and support 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 may be disclosed to relevant College 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 another law. You are able to request access to the personal information that we hold about you/your child and to request that it be corrected.

AUTHORISATION

Doctor's Name (for prescribed medication only)	
Signature:	Date:
Parent/Carer's Name	
Signature:	Date:

Office Use Only Date Received CareMonkey: YES NO	Actioned by:	Details on

MEDICATION ADMINISTRATION LOG

Name of student:_____Year Level_____

Date	Time	Name of Medication & Dose	Tick these boxes when checked				Staff member 1 Print & sign	Staff Member 2 Print & sign
			Right Child	Right Medication	Right Dose	Right Route (e.g. orally/topical /injection/inhaled)		