WODONGA PRIMARY SCHOOL

Medication Authority Form

Student name:	Student date of birth:
CLASS:	

Name of medication:			
What is this medication for?			
Start date:		**End date:**	

How much to give (dose)?	When to give (time)?	How is it given (route)?	Supervision instructions
			☐ Staff will give to student ☐ Staff will watch and help student ☐ Staff will remind student

How to store medication?			
Type of medication?	☐ Prescribed	☐ Controlled	☐ Over-the-counter

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How to store medication?			
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Authority to give medication at school (parent/carer to tick)

- ☐ I consent for this medication to be given to the student during school or school-related activities, as per the instructions above.
- ☐ I authorise the school to contact the pharmacist or prescriber on the pharmacy label or this form to check how to safely give this medicine.
- ☐ I confirm that my child has had this medicine before. This is not the first time my child has taken this medicine.
- ☐ I understand that we collect personal and health information to plan for and support the health care needs of our students which will be handled in accordance with the Privacy notice in this form.

REQUIRED – Parent/carer name:	Parent/carer signature:	Contact number:	Date signed:

IF NEEDED – Prescriber name:	Prescriber signature:	Contact number:	Date signed:

SCHOOL USE ONLY: authorisation	☐ Original pharmacy label on package or box	☐ Signed letter, action or management plan	☐ Signed by prescriber above