APPS Medication Authority Form

For a student who requires medication whilst at school

This form needs to be completed by the student's parent/carer or guardian, for all medication to be administered at school.
Please only complete those sections in this form which are relevant to the student's health support needs.

Class:_______________________________

Student's Name:____Date of Birth:______/______/___________

MedicAlert Number (if relevant): ______________________Review date for this form: ______________________

Please Note: wherever possible, medication should be scheduled outside the 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:				
Name of Medication/s	Dosage (amount)	Time/s to be taken	How is it to be taken? (eg orally/ topical/injection)	Dates
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication

Medication Storage

Please indicate if there are specific storage instructions for the medication:

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Medication delivered to the school

Please ensure that medication delivered to the school:

☐ Is in its original package

☐ The pharmacy label matches the information included in this form.

Monitoring effects of Medication

Please note: School staff *do not* monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

Authorisation:	
Name of Parent/Carer:	
Signature:	Date:
Contact phone number:	

Please note: Medication can NOT be administered without a valid signature from a Parent or Guardian.