Medication authority

for education, child/care 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 supervising staff and emergency medical personnel.

Name of child/student/client: ________________________ :First Name ____________________ Date of birth: __________
Family name, First name

MedicAlert Number (if relevant): ______________________________ Date for next review ________________________

To the doctor (or other authorised prescriber)

Please:

- *Complete all sections of this form.*
- *Schedule medication outside care/school hours wherever possible.*
- *Be specific: **As needed** is **not** sufficient direction for staff members—they need to know exactly when medication is required.*
- *Nominate the simplest method. **For example: Oral or 'puffer' medication is much 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 a doctor and is provided in the original, 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)*
	❑ 07 – 08.30 am ❑ 09 – 10.30 am ❑ 11 – 12.30 am ❑ 01 – 02.30 pm ❑ 03 – 04.30 pm ❑ 05 – 06.30 pm ❑ 07 – 08.30 pm ❑ Overnight ❑ Other *(if medically necessary)* *Please specify:* *<<Medication Time - Other (if medically necessary)>>*
Start/finish date *(if appropriate)* *from <<Medication Start (if appropriate)>> to <<Medication End (if appropriate)>>*	

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).

<<Difficulties with self-management e.g. coordination>>

This plan has been developed for the following services/settings: *

❑ School/education
❑ Child/care
Respite/accommodation
Transport
Outings/camps/holidays/aquatics
Work
Home
Other *(please specify): <<Plan developed for service/setting - Other>>*

AUTHORISATION AND RELEASE

Authorised prescriber: ____________________________ Professional role: GP

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/guardian
or adult student/client ______________________________________ Signature ___________________ Date ________________
Family name (please print) First name (please print)