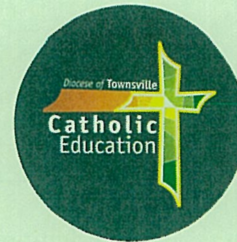
Consent to administer MEDICATION at school.

Includes OSHC



Not for School camp - *Use School Camp Consent and Medical Form*

Student Full Name: ______________________

Year Level ______________________

Date of birth: ______________________

Address: ______________________

Photo (if desired)

☐ **Asthma Reliever** – This form can be signed by the PARENT for blue coloured inhaler ONLY. For any other coloured inhalers 'Ongoing Medication" to be completed.

☐ **EVENT MEDICATION prescribed for less than 30 days:** from...../...../..... to...../...../.....
This form can be signed by the PARENT. The medication must be prescribed by a doctor and labelled accordingly.

☐ **ONGOING MEDICATION prescribed for more than 30 days** from...../...../..... to...../...../*2016*
This form MUST be completed and signed by the DOCTOR – a new form is required each school calendar year. **Includes Anaphylaxis (Allergy), Asthma, Epilepsy or Diabetes Medication.**

Paracetomol (e.g. Panadol, Herron, Panamax) Only paracetamol which **has been prescribed** to the student by a medical practitioner and labelled accordingly will be administered.

Medicare Card Number: _ _ _ _ _ _ _ _ _ _ Position (*the number next to individual's name*) : _
Card Expiry date __/___

1. Medical condition(s) of the child requiring regular treatment:

____

____

____

2. Essential medication requiring administration during school hours: (including OSHC)

Medication Name	dosage	Time/s of dosage	Special Instructions	Self-admin (Yes/No)	

3. Recommended restrictions on participation in school activities (e.g. sport, use of tools or machinery):

____

____

4. Recommended procedure in crisis situation:

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5. Additional comments:

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Consent by parent:

I understand it is my responsibility to provide the medication and equipment for its administration, and to ensure its immediate replenishment after use, or when it requires replacement.

I understand medication label must be issued for this event period *(i.e. date on packaging must be relevant to request period)*

For asthma puffers & paracetamol this form is valid up to December 31 of the current year or until date of expiry (whichever is sooner).

I understand that the information provided may be discussed by the Principal/or delegate with other members of school staff.

I hereby give permission to the Principal/or delegate, at their discretion, to obtain relevant information from the Prescribing Doctor.

I agree to collect any unused or expired medication from the school.(Medications will not be sent home with student)

I authorize the school to provide to ambulance / hospital authorities or qualified medical practitioner(s) information concerning any of the medications or conditions identified above.

I accept and agree to observe the conditions imposed by the school (workplace) and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medication.

I understand medication may be administered by a school staff member who may not have received medical training.

ASTHMA – This form has been completed in accordance with my child's **current** Asthma Management Plan

Signature of Parent/Guardian: ______________________

Name ______________________

Date: ____/____/____

Contact No. ______________________

Is this MEDICATION prescribed for more than 30 days? If yes, this form MUST also be signed by your child's doctor.

Signature of Doctor: ______________________

Name ______________________

Medical Practice: ______________________

Date: ____/____/____

Contact No. ______________________

Accepted by Principal / Delegate: ________________ Date: ____________