Consent to administer medication

Student Full Name: _____

Year Level _____

Date of birth: _____

Address: _____

Privacy Statement: Your personal information will not be disclosed to any person or agency without your express consent. Information will be maintained in confidence and stored securely in accordance with the *Information Privacy Act 2009.*

PART A:	**This form only collects the information for one (1) medication, please complete a separate form for each medication.**

Parent/carer name: **Phone No.**

- I consent to the following medication being administered (as per the instructions on the pharmacy label and/or any additional written instructions) to the student named above during school or school-related activities.
- I authorise school staff to contact the prescribing health practitioner or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication to this student.
- I understand that medication may be administered by a school staff member who is not medically trained.
- I agree to collect all unused medication from the school (medications will not be sent home with the student)
- I understand it is my responsibility to inform the principal of any changes involving the administration of the medicine.
- 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.

Name of Medication: _____

This medication is required:

☐ Routinely to manage an ongoing condition *(Complete Part A only)*

☐ Routinely for a short-term condition with a start and end date *(Complete Part A Only)*

☐ As needed for minor or non-emergency symptoms *(Complete Part A & B)*

☐ To manage a health condition by following a current Health or Action Plan *(Part A & B/attach Health Plan)*

(Please select below & attach Health Plan/Action Plan)

☐asthma ☐ anaphylaxis ☐ diabetes ☐ epilepsy ☐ cystic fibrosis ☐other:

Start date:	**End date:** *Required for routine - short term medications only*

Dose required	Time/s of dosage	Days	Special Instructions
		☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐*Saturday** ☐*Sunday**	

Does the medication require refrigeration? ☐ Yes ☐ No

Has this student previously shown any side effects after taking this medication? ☐ Yes ☐ No

If yes, describe:

Are you requesting approval for the student to self-administer? *If yes, complete Part C* ☐Yes ☐ No

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Are there any recommended restrictions on participation in school activities e.g. sports, machinery, tools? *If yes, please advise:*	☐Yes ☐ No
I confirm that the medication provided to the school (as listed above): ☐ is medically authorised (e.g. has been prescribed by a doctor, dentist, optometrist or nurse practitioner) ☐ is in the original dispensed container with intact packaging ☐ has the student's and doctor's names on the pharmacy label ☐ is current/in-date	
Parent/Carer signature:	**Date:**
Principal/Delegate Approval: *Name & Signature*	**Date:**

**for boarding schools or camp/excursions only*

PART B	**Complete for 'As needed' medications - Prescribing health practitioner to complete**
Where medication is to be taken as needed in response to a student's symptoms (e.g. migraine) or when there is varying dose instructions not specified on the pharmacy label, the school requires clear instructions to enable non-medically trained school staff to safely administer the medication.	
Student name:	**Date of birth:**
Medication:	**Dosage and route:**
This medication is to be administered as: *(please select one or both)* ☐ an emergency response ☐ a non-emergency response	
Administer the medication when these signs and symptoms occur:	
The maximum number of dosages allowed over a 24-hour period are:	
The minimum length of time allowed between dosages is:	
The expected response the student would have after having this medication administered is: If there is no response in approximately ____ minutes, take the following action [e.g. call ambulance]: ***Please note:*** *The school will notify the parent/carer if the student displays any suspected side effects following administration.*	
Please indicate if additional information is attached (if required):	YES ☐ NO ☐
Name of prescribing health practitioner:	Medical practice stamp/sticker:
Signature of prescribing health practitioner:	
Date:	
Review date of this medication order:	

Reviewed Date: 18/07/2024

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Part C	Self-administration Request

NOTE:

- **Part A & Part C of this form must both be completed when requesting approval to self-administer.**
- **Self-administration is not permitted for Schedule 8 Medicines 'Controlled Drugs'.**
- **Students aged 10 or under are not permitted to self-administer .**

In all cases and at any time, the principal/delegate may disallow student self-administration for health and/or safety reasons.

Student name: **Date of birth**

- I confirm that the student is confident, competent and can safely administer the right dose of their own medication at the right times.
- I confirm that the student can store their medication securely.
- I authorise school staff to contact the prescribing health practitioner or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication to this student

I seek approval from the principal/delegate for the student to self-administer for the following:

Health Condition: _____

Medication Name: _____

Any further supporting information: _____

Parent/carer signature:	**Date:**
Student signature:	**Date:**
Principal/Delegate Approval: *Name & Signature*	**Date:**