

# 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 \_\_\_\_\_ Date of birth \_\_\_\_\_  
Family name (please print) First name (please print)

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.

<b>MEDICATION INSTRUCTIONS</b> <small>(please print clearly)</small>		<b>TIME</b> <small>please tick administration time(s)</small>
Medication name <small>(include generic name)</small>		<input type="checkbox"/> 07 – 08.30 am <input type="checkbox"/> 09 – 10.30 am <input type="checkbox"/> 11 – 12.30 am <input type="checkbox"/> 01 – 02.30 pm <input type="checkbox"/> 03 – 04.30 pm <input type="checkbox"/> 05 – 06.30 pm <input type="checkbox"/> 07 – 08.30 pm <input type="checkbox"/> Overnight <input type="checkbox"/> Other <small>(if medically necessary)</small> <small>Please specify:</small>
Form <small>(eg liquid, tablet, capsule, cream)</small>	Route <small>(eg oral, inhaled, topical)</small>	
Strength	Dose	
Other instructions for administration		
Start/finish date <small>(if appropriate)</small> from      to		

**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).

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

- |                                                |                                                                |
|------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> School/education      | <input type="checkbox"/> Outings/camps/holidays/aquatics       |
| <input type="checkbox"/> Child/care            | <input type="checkbox"/> Work                                  |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home                                  |
| <input type="checkbox"/> Transport             | <input type="checkbox"/> Other <small>(please specify)</small> |

**AUTHORISATION AND RELEASE**

Authorised prescriber \_\_\_\_\_ Professional role \_\_\_\_\_

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)