

St Mark's Catholic Primary School



Medication Authorisation Form

Name of Student: _____ Class: _____

Parent / Guardian's Name: _____ Contact Number: _____

Treating Practitioner's Name: _____ Contact Number: _____

Address of the Treating Medical Practitioner: _____

Reason for medication: _____

Will this medication prevent your child from participating in all/any School Activities?: Yes No

If yes, please give details _____

The Medication has been delivered to the school:

Is in its original package

The pharmacy label matches the information included in this form.

Important Notes:

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.

Staff Members are not permitted to administer the first dose of a new medication in the event that it may cause an adverse reaction. The first dose of all medication must be administered by a parent / guardian or medical practitioner.

The school will not administer Paracetamol without the completion of this form as it may mask signs and symptoms of other illness or injury.

Medication required:

Name of Medication/s	Dosage (Amount)	Time/s to be taken	How is it to be taken? eg by orally / inhaled / topically	Dates
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing Medication <i>Please tick <input type="checkbox"/> if request is ongoing</i>
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing Medication <i>Please tick <input type="checkbox"/> if request is ongoing</i>
				Start date: / / End Date: / / <input type="checkbox"/> Ongoing Medication <i>Please tick <input type="checkbox"/> if request is ongoing</i>

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Medication Storage

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

Monitoring effects of Medication

Please note: School Staff will seek emergency medical assistance if concerned about a student's behaviour following the administration of medication.

Privacy Statement

The school collects personal information to assist with the planning and support of the health care needs of the student. Without the provision of this information the quality of the health support provided may be affected. The information listed in this form may be disclosed to relevant School Staff and appropriate Medical Personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by law.

Authorisation

By signing below I hereby authorise staff at **St Mark's Catholic Primary School** to administer medication to my child in accordance with the information provided above. I also give permission for the school to contact the Treating Medical Practitioner listed above if confirmation or further information about the administration of medication is required.

Parent / Guardian's Name: _____

Signature: _____

Date: _____