TEMPLESTOWE VALLEY PRIMARY SCHOOL

Medication Authority Form

For a student who requires medication whilst at school

NB: *ANAPHYLAXIS requires a separate ASCIA Action Plan/ ASTHMA requires a separate School Asthma Action Plan*

Student Name: _____ Date of Birth: _____

Teacher: _____ Room: _____

Emergency Contact: _____ Telephone Number: _____

Please Note: 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.

Medication required:

Name of Medication/s	Dosage (amount)	Time/s to be taken	How is it to be taken? (e.g. orally/topical/ injection)	Dates
				Start date: ___/___/___ End Date: ___/___/___ ☐ Ongoing medication
				Start date: ___/___/___ End Date: ___/___/___ ☐ Ongoing medication

Medication storage:

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

Medication delivered to the school needs -

☐ to be in its original package

☐ the pharmacy label to match the information included in this form

Monitoring effects of Medication:

Please note: School staff *do not* monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

Privacy Statement

The school collects personal information so as the school can plan and support the health care needs of the student. The information may be disclosed to relevant school staff and appropriate medical personnel.

I hereby give **consent** for this medication to be administered to my child as directed herein. I further consent that medical attention may be sought for my child should it be deemed necessary

Parent Signature: _____ Date: _____