ASPIRATION

GROWTH

COURAGE

RESPECT

DEPARTMENT OF EDUCATION learners first

AUTHORISATION FOR ADMINISTRATION OF STUDENT MEDICATION

FORM A: Non-prescription medication – to be completed by Parent/Carer

Student Name:								
School:	Year Level:	Year Level:						
NON-PRESCRIBED medica	tion to be given to stude	nt during school hc	ours:					
Name of medication	Expiry date	Dose	Route (mouth, nasa spray etc.)	l Frequency or Time	Relation to meals or N/A	In original container?*	Student permitted to self-administer	
						Yes / No	Yes / No	
						Yes / No	Yes / No	
						Yes / No	Yes / No	
I understand that this form provides aut notify the school IMMEDIATELY if this i administer medication if it is not supplied	information changes. *I und	erstand that all medi						
Parent/Carer Name:				Relationship to student:				
Address:	::			Phone number:				
Signature:			Date:	_ _				



ASPIRATION

Student Name:

School:

GROWTH

Department of Education

COURAGE

RESPECT

AUTHORISATION FOR ADMINISTRATION OF STUDENT MEDICATION

FORM B: Prescription medication – To be completed by a Doctor/Pharmacist/Practise Nurse

Year Level:

DEPARTMENT OF
EDUCATION
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Tasmanian

PRESCRIBED medication to be given to student during school hours:											
Name of medication	Expiry date	Type of medication (e.g. S8, S4d)	Dose and route	Frequency or Time	Relation to meals or N/A	Side effects, if any	In original container with instructions?*	Student permitted to self-administer?			
							Yes / No	Yes / No			
							Yes / No	Yes / No			
							Yes / No	Yes / No			
I understand that this form provides authorisation for administration, or self-administration (if indicated), of prescribed medication to the student named. I understand that I should notify the school IMMEDIATELY if this information changes. *I understand that all medication MUST be supplied in the original container or a Webster-pak, with instructions, and that the school cannot administer medication if it is not provided in the original container or Webster-pak.											
Name:				Pro	ofession (circle):	Doctor / Pharmaci	st / Practise Nurs	е			
Address:				Pho	one number:						
Signature:				Dat	te:						
Parent/Guardian Signature:				 Dat	te:						
-							_				

Personal information collected on this form is used to provide support services for your child. This will only be used for the primary purpose for which it is

gathered, except where authorised or mandated by legislative requirements (e.g. Mandatory Reporting). For further information, contact Learning Services.