



**ONGOING MEDICATION ADMINISTRATION
AND TREATMENT AUTHORITY**

STUDENT NAME: _____ DATE: _____

SECTION A - Medication required during school hours:

| Time | Medication Name | Dosage | Type e.g. oral/ topical | Storage |
|------|-----------------|--------|----------------------------|---------|
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Medication prescribed by a medical practitioner MUST have a pharmacy label attached.

All medication MUST have the following details clearly labelled on the box/bottle:

- Student's name
- Name of the medication
- Dosage amount to be given
- Time the medication is to be administered.
- Expiry date

Initial doses of medication will not be administered at school. Staff are not able to monitor effects.

SECTION B - Medication taken at home:

This information is very important if your child ever requires an ambulance to be called at school.

Please list medication below - **if "nil" please write "nil"**.

| Time | Medication Name | Dosage | Type e.g. oral/ topical | Storage |
|------|-----------------|--------|----------------------------|---------|
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MEDICAL PRACTICE

Medical Practitioner Name: _____ Medical Practitioner Signature: _____

Name of Clinic _____ Clinic Phone Number: _____

PARENT/CARER AUTHORITY

Parent/Carer Name: _____

Parent/Carer Signature: _____ Date: _____