

## AUTHORISATION FOR ADMINISTRATION OF STUDENT MEDICATION

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

Student name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

School: \_\_\_\_\_

Year level: \_\_\_\_\_

**NON-PRESCRIBED** medication to be given to student during school hours:

Name of medication	Expiry date	Dose	Route (mouth, nasal spray etc.)	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
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						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 **non-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 Webster-pak, and that the school cannot administer medication if it is not supplied in the original container or Webster-pak.

Parent/Carer Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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.