DEPARTMENT OF EDUCATION learners first

AUTHORISATION FOR ADMINISTRATION OF STUDENT MEDICATION

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

Student Name: _____

School: _____ Year Level: _____

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: _____ Profession (circle): Doctor / Pharmacist / Practise Nurse

Address: _____ Phone number: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____