Medication Authority Form
St Paul Apostle South P.S.

Student Details

Name of Student	
Date of Birth	
Date of medication to be administered at school	

Medication(s) to be administered at school

Name of Medication	
Dosage (amount)	
Time/s to be taken	
How is it to be taken? (e.g. oral/topical/ injection)	
Dates to be administered	**Start:** **End:** **OR** ☐ **Ongoing medication**
Supervision required?	☐ **No student self- managing** ☐ **Yes** ☐ **remind** ☐ **observe** ☐ **assist** ☐ **administer**

Medication taken to/stored at the school

Indicate if there are any specific storage instructions for any medication:

Important requirements for the medication to be administered:

***Ensure that medication taken to the school is in its original package with original labels. Please note School staff will seek emergency medical assistance if concerned about a student's condition following medication*.**

Please outline the reasons the administration of medication is required.

Privacy Statement

We collect personal and health information to plan for and support the health care needs of our students. Information collected will be used and disclosed in accordance with **St Paul Apostle South P.S**. published Privacy Policy.

Authorisation to administer medication in accordance with this form

Parent Name	
Signature	
Date	
Telephone	
Health practitioner name	
Health practitioner signature	
Practice name	
Contact details	
Telephone	
AHPRA registration	
Patient URL number	
Date	