DEPARTMENT OF EDUCATION
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AUTHORISATION FOR ADMINISTRATION OF STUDENT MEDICATION

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

Student Name: ______________________________

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

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.

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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: ______________________

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Tasmanian Government