ASPIRATION GROWTH COURAGE RESPECT

DEPARTMENT OF EDUCATION learners first

AUTHORISATION FOR ADMINISTRATION OF STUDENT MEDICATION

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

Student name: _____ Date of birth: _____

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
							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 Webster-pak, and that the school cannot administer medication if it is not supplied in the original container or Webster-pak.

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

Address: _____ Phone number: _____

Signature: _____ Date: _____

Parent/Guardian 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.

Tasmanian Government