



MEDICATION AUTHORITY FORM

For a student that requires medication at school

This form is to be completed by the student's parent/carer or medical practitioner, for all medication to be administered at school. For those students with asthma, an Asthma Action Plan must be completed. For those students with Anaphylaxis, an Anaphylaxis Action Plan must be completed. For those students with an allergy, an Allergy Action Plan must be completed. **All Action Plans MUST be signed by a medical Practitioner in order to be compliant.**

Please only complete those sections in this form which are relevant to the student's health support needs.

Name of School: **RED HILL CONSOLIDATED SCHOOL**

Student's name: _____ Date of Birth: _____

Medical Alert Number (if relevant): _____ Date Today: _____

Please note: wherever possible, medication should be scheduled outside the school hours, e.g. medications required three times a day is generally not required during a school day: It can be given before and after school and before bed.

MEDICATION REQUIRED

Name of Medication	Dosage	Time/s	Date: start/end

Additional instructions: How is it to be taken? Storage?

Parent/Carer/Medical Practitioner Name: _____

Parent/Carer/Medical Practitioner Signature: _____