Consent to administer medication

PLEASE NOTE:

For medication to be administered at school or during school-related activities, there must be medical authorisation for the student to have that medication, and the medication must be in its original container with intact packaging.

Examples of medical authorisation include:

- a pharmacy label with both the student's and doctor's name on it;
- a signed letter from a doctor;
- a medication order from a dentist;
- an Action Plan signed by a doctor or nurse practitioner.

See below for examples of health conditions, medications and associated documentation:

Health condition/ reason for medication	**Example of medication**	**Documentation completed by doctor or other prescribing health practitioner**
Asthma	Asthma puffer	*Asthma action plan*
Anaphylaxis	EpiPen	ASCIA *Anaphylaxis Action Plan*
Diabetes	Insulin injection, insulin pump	Department of Education *Medication order to administer 'as-needed' medication at school* or medication order or *diabetes management plan* or other written instructions from prescribing health practitioner
Other types of emergency medication e.g. for seizures	Midazolam	Department of Education *Medication order to administer 'as-needed' medication at school*
Medication required 'as needed' for minor or non-emergency symptoms	Ointment for skin allergies, antihistamines	Department of Education *Medication order to administer 'as-needed' medication at school*
Changes to dosage (e.g. from ½ to 1 tablet)	Ritalin	Written instructions from prescribing health practitioner (e.g. doctor)

1. To request that the school administer medication to a student

1) Complete Section A (page 2).
2) Provide the school with the medication in the original container with intact packaging.
3) Provide the written medical authorisation (e.g. completed pharmacy label, medication order, action plan) completed and signed by the prescribing health practitioner.
4) Make an appointment with the principal/delegate if:
   - the student requires medication as an emergency response;
   - you would like the student to self-administer their medication;
   - the student has complex health support needs or requires other support strategies; or
   - you have any concerns about the student's health which may affect their schooling.

2. To request a student self-administer their medication

1) Complete Section A (page 2) and Section B (page 3).

Consent to administer medication

Privacy Statement
The Department of Education (DoE) is collecting this personal information for the purpose of enabling school staff to administer medication to the nominated student, or to support a student to self-administer their medication while at school or during school-related activities. This information will only be accessed by authorised departmental employees. In accordance with section 426 of the *Education (General Provisions) Act 2006* (regarding student's personal information) and the *Information Privacy Act 2009* (parent/carer's personal information) this information will not be disclosed to any other person or body unless DoE has been given permission or is required or authorised by law to disclose the information.

Section A: *Complete the details below:*

NOTE: This form only collects information for one (1) medication. If more than one medication is required, please complete a separate form for each medication.

Student name		**Date of birth**	
Parent/carer name		**Phone number**	

- I consent to the following medication being administered (as per the instructions on the pharmacy label and/or any additional written instructions) to the student named above during school or school-related activities.
- I authorise school staff to contact the prescribing health practitioner or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication to this student.

Name of medication	

I confirm that the medication provided to the school (as listed above):

☐ is medically authorised *(e.g. has been prescribed by a doctor, dentist, optometrist or nurse practitioner)*
☐ is in the original dispensed container with intact packaging
☐ has the student's and doctor's names on the pharmacy label *(if there is no other written evidence of medical authorisation)*
☐ is current/in-date *(*The expiry date of the medication is _ _ / _ _ / _ _ _ _*).*

The medication is required:		If **Yes** to any questions, complete the following:
(a) routinely (e.g. 11am every day)	☐ **No** ☐ **Yes⇨**	Administer at _ _: _ _ am/pm on the following days: *(circle the day/s required)* Monday Tuesday Wednesday Thursday Friday
(b) for a short time only (e.g. only for 2 weeks)	☐ **No** ☐ **Yes⇨**	Start date: _ _ /_ _ / _ _ _ _ End date: _ _ /_ _ / _ _ _ _
(c) to manage a health condition by following a current action plan or health plan	☐ **No** ☐ **Yes⇨**	Is the medication for: ☐ asthma ☐ anaphylaxis ☐ diabetes ☐ epilepsy ☐ cystic fibrosis ☐ other *(describe)*
(d) 'as needed' to treat minor or non-emergency symptoms	☐ **No** ☐ **Yes⇨**	☐ I understand that before the school administers this medication, if they are not aware of when this medication was most recently given to this student, I will be contacted to provide this information.

Has this student previously shown any side effects after taking this medication?	**Yes** ☐ **No** ☐

If **Yes**, describe: _____

Parent/carer/student signature		**Date**	

If the student is to self-administer this medication, also complete **Section B**
NOTE: Controlled drugs cannot be self-administered.

Section B*: Details for student self-administration of medication:*			
In all cases and at any time, the principal/delegate may disallow student self-administration for health and/or safety reasons.			
Student name		**Date of birth**	

- I confirm that the student is confident, competent and can safely administer the right dose of their own medication at the right times.
- I confirm that the student can store their medication securely.
- I authorise school staff to contact the prescribing health practitioner, health team or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication by this student.

Health condition	
☐ Asthma - secondary school students only	☐ I approve for the student to self-administer their asthma medication. **NOTE:** The school will need a copy of the student's *Asthma Action Plan* if it varies from the standard asthma first aid response

Health condition	I seek approval from the principal/delegate for the student to self-administer:
☐ Asthma	☐ their asthma medication *(following a current action plan/health plan)*
☐ Anaphylaxis	☐ their adrenaline auto-injector *(following a current action plan/health plan)*
☐ Diabetes	☐ their medication *(following a current health plan)*
☐ Cystic fibrosis	☐ their medication *(following a current health plan)*
☐ Other _____	☐ their medication *(following a current health plan)*

Parent/carer/student signature		**Date**	

Record of medication administration (routine medication)

<Insert/attach student photo if required for identification purposes>

Student name		Date of birth		Class		Dosage time/s	
Medication						Route	

On receipt of the medication:

1. *Check that the medication is in the original container and is intact (e.g. tablets in blister packs are sealed)*
2. *Check for medical authorisation e.g. pharmacy label, other written authorisation*
3. *Advise the parent/carer that they will need to collect any unused medication when it is no longer required to be administered at school*
4. *Attach the completed **Consent to administer medication** form*
5. *Attach Individual Health Plan if one is required*
6. *Refer to all information when administering medication.*

Initial the appropriate box below to confirm when the medication was administered, or enter the appropriate code from the key below.

KEY: A – Student absent; **S** – Student self-administration; **P** – Parent/carer administered medication; **X** – School closed; **O** – Student off campus; **N/S** – No supply of medication→contact parent/carer; **R** – Student refused medication→contact parent/carer; **V** – Student vomited following medication→contact parent/carer

Note: The table allows for the recording of up to two doses of the medication per day. Amend the document electronically to add additional lines if more than two doses per day are required.

If a student requires multiple doses of the same medication at differing strengths, use one form per dose strength e.g. one form for Lamotrigine 25 mg and one form for Lamotrigine 50 mg.

MTH	DOSAGE TIME/S	DATE																												
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan																																
Feb																																
Mar																																

Student name		Date of birth		Class		Dosage time/s	
Medication						Route	

MTH	DOSAGE TIME/S	DATE																												
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