St John's Lutheran School ~ Eudunda
MEDICATION AUTHORITY FORM

COPIES OF THIS FORM ARE AVAILABLE FROM THE FRONT OFFICE AND ON OUR SCHOOL WEBSITE

This form is to be completed by the student's authorised Medical/Health Practitioner, for all medication to be administered at school. Medication is to be given to the school's First Aid Officer.

Name of student: ______________________ Date of birth: ______________________

Review date: ______________________ Allergy: ______________________

Please Note: Medication should be scheduled outside school hours wherever possible.

Name of Medication/s and purpose eg Panadol tablet for tooth pain	Dosage (amount)	Time/s to be taken	How it is to be taken? eg orally, inhaled, topical	Dates
				Start date: / / End date: / / ☐ Ongoing medication
				Start date: / / End date: / / ☐ Ongoing medication
				Start date: / / End date: / / ☐ Ongoing medication
Please indicate if there are specific storage instructions for any of the above medications:				

Please ensure that medication delivered to the school:

- **Is in its original packaging**
- **Has a pharmacy label matching the information on this form.**

Please Note: School staff *do not* monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

**** If additional advice is required, please attach to this form.****

Authorisation:

Medical/Health Practitioner Authority:	**Parent/Caregiver:**
Name:	**I have read, understood and agreed with this plan. I approve the release of this information to supervising staff and emergency medical personnel.**
Professional Role:	
Date:	**Parent/Caregiver:**
Contact Details:	**Signature:**

Adapted from: Maitland Lutheran School and DECS Medication Authority Forms