



# MEDICATION REQUEST FORM

STUDENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

DATE: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ PH: \_\_\_\_\_

This form should, ideally, be signed by the student's medical/health practitioner for all medication to be administered at school but schools may proceed on the signed authority of parents in the absence of a signature from a medical practitioner.

- For students with asthma, [Asthma Australia's School Asthma Care Plan](#)
- For students with anaphylaxis, an [ASCIA Action Plan for Anaphylaxis](#)

Please only complete the sections below that are relevant to the student's health support needs. If additional advice is required, please attach it to this form.

**Please note: wherever possible, medication should be scheduled outside school hours, eg medication required three times daily is generally not required during a school day – it can be taken before and after school and before bed.**

NAME of Medication: \_\_\_\_\_

Dosage (Amount): \_\_\_\_\_ Times To Be Taken \_\_\_\_\_

Date To Commence: \_\_\_\_\_ Date To Finish: \_\_\_\_\_

Storage Instructions: \_\_\_\_\_

**Medication Has Been Delivered To School:**

- in its original package       pharmacy label matches information included in this form

**Monitoring the effects of Medication:**

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.

**Privacy Statement:**

We collect personal and health information to plan for and support the health care needs of our students. Information collected will be used and disclosed in accordance with the Department of Education and Training's privacy policy which applies to all government schools (available at:

<http://www.education.vic.gov.au/Pages/schoolsprivacypolicy.aspx>) and the law.

**Authorisation to Administer Medication in accordance with this form:**

Name of parent/carer: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of health practitioner: \_\_\_\_\_ Professional role: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact details: \_\_\_\_\_

Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_