Consent to administer MEDICATION at school.

Includes OSHC

Not for School camp - *Use School Camp Consent and Medical Form*

Student Full Name: _____

Year Level _____

Date of birth: _____

Address: _____

Photo (if desired)

☐ **Asthma Reliever** – This form can be signed by the PARENT for blue coloured inhaler ONLY.
For any other coloured inhalers 'Ongoing Medication" to be completed.

☐ **EVENT MEDICATION prescribed for less than 30 days:** from…../…../….. to…../…../…..
This form can be signed by the PARENT. The medication must be prescribed by a doctor and labelled accordingly.

☐ **ONGOING MEDICATION prescribed for more than 30 days** from…../…../….. to…../…../*2016*
This form MUST be completed and signed by the DOCTOR – a new form is required each school calendar year. **Includes Anaphylaxis (Allergy), Asthma, Epilepsy or Diabetes Medication.**

Paracetomol (e.g. Panadol, Herron, Panamax) Only paracetamol which **has been prescribed** to the student by a medical practitioner and labelled accordingly will be administered.

Medicare Card Number: _ _ _ _ _ _ _ _ _ _ _ Position (*the number next to individual's name*) : _
Card Expiry date __/___

1. Medical condition(s) of the child requiring regular treatment:

_____
_____
_____

2. Essential medication requiring administration during school hours: (including OSHC)

Medication Name	dosage	Time/s of dosage	Special Instructions	Self-admin (Yes/No)	

3. Recommended restrictions on participation in school activities (e.g. sport, use of tools or machinery):

_____
_____

4. Recommended procedure in crisis situation:

_____
_____

5. Additional comments:

_____
_____
_____

Consent by parent:

- ☐ I understand it is my responsibility to provide the medication and equipment for its administration,
- ☐ and to ensure its immediate replenishment after use, or when it requires replacement.
- ☐ I understand medication label must be issued for this event period *(i.e. date on packaging must be relevant to request period)*
- ☐ For asthma puffers & paracetamol this form is valid up to December 31 of the current year or until date of expiry (whichever is sooner).
- ☐ I understand that the information provided may be discussed by the Principal/or delegate with other members of school staff.
- ☐ I hereby give permission to the Principal/or delegate, at their discretion, to obtain relevant information from the Prescribing Doctor.
- ☐ I agree to collect any unused or expired medication from the school.(Medications will not be sent home with student)
- ☐ I authorize the school to provide to ambulance / hospital authorities or qualified medical practitioner(s) information concerning any of the medications or conditions identified above.
- ☐ I accept and agree to observe the conditions imposed by the school (workplace) and understand and
- ☐ agree that it is my responsibility to inform the Principal of any changes involving the administration of the medication.
- ☐ I understand medication may be administered by a school staff member who may not have received medical training.
- ☐ ASTHMA – This form has been completed in accordance with my child's **current** Asthma Management Plan

Signature of Parent/Guardian: _____
Name _____
Date: ____/____/____
Contact No. _____

Is this MEDICATION prescribed for more than 30 days? If yes, this form MUST also be signed by your child's doctor.

Signature of Doctor: _____
Name _____
Medical Practice: _____
Date: ____/____/____
Contact No. _____

Accepted by Principal / Delegate: _____ Date: _____