ADMINISTRATION OF MEDICATION AUTHORISATION
Parent/Guardian

This form is used to provide authorisation to Holy Rosary Catholic School to:

a) administer **non-prescribed** medication to your child.
b) administer **prescribed** medication to your child (to authorise the school to allow your child to self-medicate, you must **also** arrange for a doctor, or the pharmacist dispensing the medication or a practice nurse from the prescribing doctor's surgery to complete the form "Administration of Prescribed Medication Authorisation Form (Doctor/Pharmacist/Practice Nurse).
c) allow your child to self-administer their prescribed medication.

Student's Name	Surname/Family Name___________________________ Given Name(s)_________________________________
Medication to be given to student during school hours, as prescribed/authorised by the student's medical practitioners/pharmacist/practice nurse.	Name of Medication_____________________________ ____ Expiry Date_____________________________________ Dose and route (eg by mouth, by injection) ____ Frequency______________________________________ Relation to meals or n/a__________________________ Side effects, if any, school staff should be made aware of____ ____ Medication has been supplied in original container with the instructions provided by the pharmacist Yes/No Is the student permitted to self-administer this medication? Yes/No
Parent/Guardian's signature	Parent/Guardian name (Please print) ____ Address____ ____ Signature________________________Date___________

IMPORTANT: Please notify the school immediately of any changes to the details above.

ADMINISTRATION OF PRESCRIBED MEDICATION AUTHORISATION
Doctor/Pharmacist/Practice Nurse

- This form is used to provide authorisation to Holy Rosary Catholic School to:

a) administer **prescribed** medication to your child named on the form.
b) Allow the child named on the form to self-administer prescribed medication.

- This form must be completed either by a doctor, or the pharmacist dispensing the medication or a practice nurse from the prescribing doctor's surgery.
- Please complete the appropriate sections.

Student's Name	Surname/Family Name_________________________ Given Name(s)_______________________________
Oral Medication to be given to student during school hours	Name of Medication__________________________________ Type of Medication (eg S8, S4d) ____ Dose and route______________________________________ Frequency____ Relation to meals or n/a______________________________ Side effects, if any, school staff should be made aware of ____ Is the student permitted to self-administer this medication? Yes/No
EpiPen Treatment to be given to student when sign/symptoms occur during school hours after known or suspected exposure.	Student has severe allergic reaction to: ____ Allergic reaction is a result of the student being exposed to:____ The following signs/symptoms result from exposure: ____ ____ ____ Name of medication__________________________________ Expiry date____________ Frequency____________________ Dosage and route______________________________________ Staff member to administer medication:___________________
Signature Please circle relevant profession: Doctor Pharmacist Practice Nurse	Name (Please print)___________________________________ Address____ ____ Signature______________________ Date__________

IMPORTANT: Please notify the school immediately of any changes to the details above.