

Photo of student

Name .....

Year .... 2015

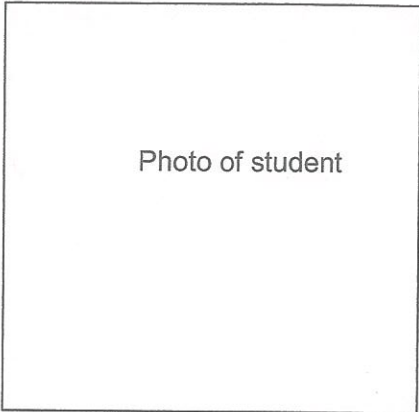
# Medical Plan

## 2015





# Cover sheet Individual health care plan



School: \_\_\_\_\_ Phone: \_\_\_\_\_

Region:	Northern Sydney Region
Student:	
ERN:	
Medicare Number:	
DOB:	
Health condition(s) including allergies:	
Medication(s) at school:	
Other support at school:	
Parent/Carer contact (1)	Surname: First name: Relationship to child: Address: Home phone: Work phone: Mobile phone:

Parent/Carer information (2)	Surname: First name: Relationship to child: Address. Home phone: Work phone: Mobile phone:
Other contacts ( if Parents /Carers unavailable)	Surname: First name: Relationship to child: Address. Home phone: Work phone: Mobile phone:
Medical practitioner/doctor contact:	Surname: First name: Relationship to child: Address: Phone: Email (if known): Mobile phone (if known): Fax (if known):
Emergency Care Issues: <i>Note: An emergency care/ response plan is required if the student is identified at risk of an emergency reaction.</i> <hr/> <hr/> <hr/>	

Emergency Service Contacts: ( eg ambulance, local hospital, medical centre)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Any special medical notes relating to religion, culture or legal issues, eg. blood transfusions.

*Note: If the student is transferred to the care of medical personnel, eg paramedics this information, will if practicable in the circumstances, be provided to those personnel. It will be a matter for the professional judgment of the medical personnel whether to act on the information.*

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Please tick which of the following documents are attached as part of the individual health care plan:

- An emergency care/response plan
- A statement of the agreed responsibilities of different people involved in the student's support
- A schedule for the administration of prescribed medication
- A schedule for the administration of health care procedures
- An authorisation to contact the medical practitioner
- Other documents – please specify

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This individual health care plan has been developed as part of the learning support plan, in consultation with those indicated below and overleaf and with the knowledge and agreement of the student's parent/caregiver. Information has been provided by:

- Student                       Parent/Carer                       GP                       Medical specialist



Department staff involved in plan development:

- |          |              |
|----------|--------------|
| 1. _____ | Phone: _____ |
| 2. _____ | Phone: _____ |
| 3. _____ | Phone: _____ |
| 4. _____ | Phone: _____ |

Health care personnel involved in managing the student's health at school: ( eg. Community Nurse, Therapist)

- |          |              |
|----------|--------------|
| 1. _____ | Phone: _____ |
| 2. _____ | Phone: _____ |
| 3. _____ | Phone: _____ |

The plan will be reviewed on:.....

*NOTE: Health care plans should be reviewed at least annually or when the parent notifies the school that the student's health needs have changed. Principals can also instigate a review of the health care plan at other times.*

Signature of Parent/Carer: ..... Date .....

Signature of Principal: ..... Date .....

**NOTES:**

*Information in this individual health and emergency care plan remains specific to meet the needs of the individual student named and should not be applied to the care of any other student with similar health and emergency care needs. All individual health and emergency care plans must take into account issues of confidentiality and privacy to ensure information about the student is treated appropriately.*

*The school and the Department are subject to the Health Records and Information Privacy Act 2002. The information on this form is being collected for the primary purpose of ensuring the health and safety of students, staff and visitors to the school. It may be used and disclosed to medical practitioners, health workers including ambulance officers and nurses, government departments or other schools (government and non-government) for this primary purpose or for other related purposes and as required by law. It will be stored securely in the school.*

## Student details – additional information

NOTE: this form replaces the Student Medical Details on page 7 of the current purple enrolment form.

Student name

### H. Student medical details and health conditions

It is essential you inform the school before your child is enrolled if he or she has any medical conditions. This must include any known allergies. You should also contact the school as soon as you are aware of any newly diagnosed allergies/other medical conditions or changes to an existing condition. This will assist the school to support the safety and wellbeing of your child and allow planning to occur to determine the best way to meet the individual health and support needs of your child. This is important information for your child's safe participation at the school.

Note: Where the words 'your child' are used, they should be taken as a reference to the student seeking enrolment.

Student's Medicare number

Doctor's name/medical centre

Doctor's address (eg 1 High Street, Sydney, NSW, 2000)

Doctor's phone number (work)

Please provide the name, address and phone number of any other doctor or medical specialist who may currently be treating your child for any allergy or other medical condition you may list when completing Section H. Attach an additional page if required.

Allergy / Medical Condition	Doctor's Name	Address	Telephone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If your child has a documented plan to support any health or medical needs from a previous school or organisation (eg preschool, occasional care, etc) please provide it to the school as an attachment to this form.

### ALLERGIES – THESE CAN INCLUDE ALLERGIES TO INSECT STINGS, DRUGS, LATEX, FOOD (EG NUTS, EGGS, PEANUTS) OR OTHER.

If your child has an allergy, please specify in the box below. For this allergy, answer the 11 questions that follow (where applicable). If there is insufficient space, please attach additional pages clearly marked 'Section H'.

For any **additional allergies** your child has, **please answer each of the 11 questions** (where applicable) on a separate page for each allergy. Attach this additional information (clearly marked 'Section H') to the back of this form.

Allergy to:

1. Has a doctor diagnosed this allergy?  Yes  No

2. Is this a severe allergy (anaphylaxis)?  Yes  No

Anaphylaxis is a severe, potentially life-threatening, allergic reaction.

3. Has your child been hospitalised with a severe allergic reaction (anaphylaxis) or any other allergy?  Yes  No

4. If yes, which hospital?

5. Does your child have an ASCIA Action Plan for Anaphylaxis?  Yes  No

6. If yes, is this plan attached?  Yes  No

7. Has your child been prescribed an adrenaline autoinjector (ie EpiPen®/Anapen®)?  Yes  No

If your child has been prescribed an adrenaline autoinjector, you will need to provide the school with one (and renew prior to expiry date).







## Student details – additional information

8. What is the expiry date of the adrenaline autoinjector that will be provided to the school?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
month			year			

*If not known at the time of completing this form, the school will require this information on enrolment.*

9. Does your child have an ASCIA Action Plan for Allergic Reactions?  Yes  No

10. If yes, is this plan attached?  Yes  No

*It is important that a copy of any updated plan is provided to the school.*

11. Please list any other medication prescribed for this allergy

*The school will require further details in relation to prescribed medication on enrolment.*

*Parents of children who require their child to be administered prescribed medication at school must complete a written request. The school can provide you with a copy of a request form. Information is also available on the Department's website.*

### **MEDICAL CONDITIONS OTHER THAN ALLERGIES AND ANAPHYLAXIS (EG ASTHMA, SEVERE ASTHMA, DIABETES, EPILEPSY)**

*Please identify and provide details below of any other medical condition for which your child is being treated. (If more than one condition or insufficient space, please attach additional pages and include answers to all 7 questions that follow).*

Medical condition

1. Has a doctor diagnosed this condition?  Yes  No

2. Has your child been hospitalised with this condition?  Yes  No

3. If yes, which hospital?

4. Does your child have a documented action plan from a doctor (eg asthma action plan)?  Yes  No

5. If yes, is this plan attached?  Yes  No

6. Is your child taking prescribed medication for this condition?  Yes  No

7. If yes, what is the prescribed medication?

*The school will require further details in relation to prescribed medication on enrolment.*

*Parents of children who require their child to be administered prescribed medication at school must complete a written request. The school can provide you with a copy of a request form. Information is also available on the Department's website.*



## FIRST AID TREATMENT FOR ANAPHYLAXIS

Anaphylaxis is a severe allergic reaction and potentially life threatening. It should always be treated as a medical emergency, requiring immediate treatment. Most cases of anaphylaxis occur after a person with a severe allergy is exposed to the allergen they are allergic to (usually a food, insect or medication).

### STEP 1

**In some cases, anaphylaxis is preceded by signs of a mild to moderate allergic reaction:**

- Swelling of face, lips and eyes
- Hives or welts on the skin
- Tingling mouth
- Stomach pain, vomiting (these are signs of a mild to moderate allergic reaction to most allergens, however, in insect allergy these are signs of anaphylaxis).

### ACTION

- For insect allergy, flick out the sting if it can be seen (but do not remove ticks)
- Stay with person and call for help
- Give medications if prescribed (whilst antihistamines may be used to treat mild to moderate allergic reactions, if these progress to anaphylaxis then adrenaline is the only suitable medication)
- Locate **adrenaline autoinjector** if available (instructions are included in the Action Plan for Anaphylaxis which should be stored with the adrenaline autoinjector)
- Contact parent/guardian or other emergency contact.

### STEP 2

**Continue to watch for any one of the following signs of anaphylaxis (severe allergic reaction):**

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Loss of consciousness and/or collapse
- Pale and floppy (in young children)

### ACTION

- **Give the adrenaline autoinjector** if available (instructions are included in the ASCIA Action Plan for Anaphylaxis, stored with the adrenaline autoinjector)
- **Call Ambulance** (Telephone 000 in Australia, 111 in New Zealand or 112 if using a mobile phone)
- **Lay person flat and elevate legs - if breathing is difficult, allow to sit but do not stand**
- Contact parent/guardian or other emergency contact
- Further adrenaline doses may be given (when an additional adrenaline autoinjector is available), if there is no response after 5 minutes.

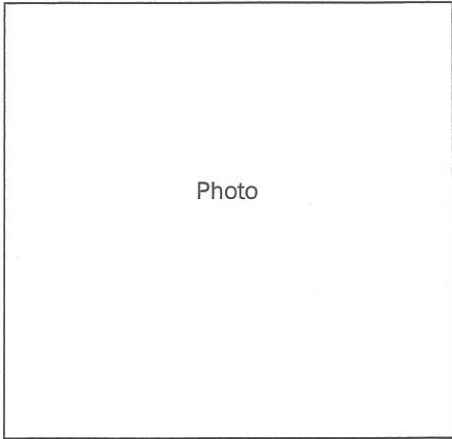
### If in doubt, give the adrenaline autoinjector

- **Adrenaline is life saving and must be used promptly. Withholding or delaying the giving of adrenaline can result in deterioration and death.** This is why giving the adrenaline autoinjector is the first instruction on the ASCIA Action Plan for Anaphylaxis. If cardiopulmonary resuscitation (CPR) is given before this step there is a risk that adrenaline is delayed or not given.
- **In the ambulance** oxygen will usually be administered to the patient by paramedics.
- **Medical observation** of the patient in hospital for at least 4 hours is recommended after anaphylaxis.
- **Adrenaline autoinjectors** available in Australia and New Zealand are EpiPen and Anapen. The Junior versions of EpiPen and Anapen are generally prescribed for children aged 1 to 5 years.



Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_



Photo

Confirmed allergens:

Family/emergency contact name(s):

\_\_\_\_\_

Work Ph: \_\_\_\_\_

Home Ph: \_\_\_\_\_

Mobile Ph: \_\_\_\_\_

Plan prepared by:

Dr: \_\_\_\_\_

I hereby authorise medications specified on this plan to be administered according to the plan.

Signed:

\_\_\_\_\_

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

Date of next review: \_\_\_\_\_

Note: The ASCIA Action Plan for Allergic Reactions is for people with mild to moderate allergies, who need to avoid certain allergens.

For people with severe allergies (and at risk of anaphylaxis) there are ASCIA Action Plans for Anaphylaxis, which include adrenaline autoinjector instructions.

Instructions are also on the device label and at: [www.allergy.org.au/anaphylaxis](http://www.allergy.org.au/anaphylaxis)

## MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

## ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy, flick out sting if visible. Do not remove ticks.
- Stay with person and call for help.
- Give other medications (if prescribed).....
- Phone family/emergency contact.

**Mild to moderate allergic reactions may not always occur before anaphylaxis**

Watch for **ANY ONE** of the following signs of anaphylaxis

## ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)

## ACTION FOR ANAPHYLAXIS

**1 Lay person flat. Do not allow them to stand or walk.**

**If breathing is difficult allow them to sit.**

**2 Give adrenaline autoinjector if available.**

**3 Phone ambulance\*: 000 (AU) or 111 (NZ).**

**4 Phone family/emergency contact.**

**Commence CPR at any time if person is unresponsive and not breathing normally.**

\*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

## IF UNCERTAIN WHETHER IT IS ANAPHYLAXIS OR ASTHMA

- Give adrenaline autoinjector FIRST, then asthma reliever.
- If someone with known food or insect allergy suddenly develops severe asthma like symptoms, give adrenaline autoinjector FIRST, then asthma reliever.

Asthma: Y  N  Medication: \_\_\_\_\_

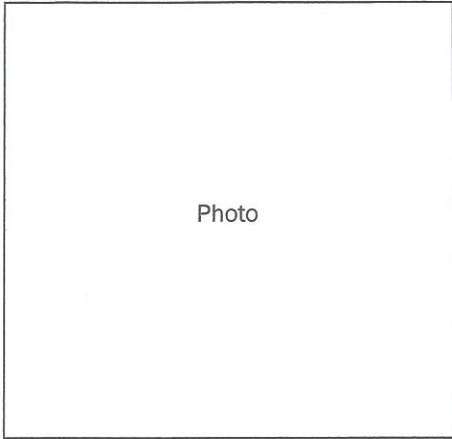


# ACTION PLAN FOR Anaphylaxis

For use with EpiPen® adrenaline autoinjectors

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_



Photo

Confirmed allergens:

Family/emergency contact name(s):

Work Ph: \_\_\_\_\_

Home Ph: \_\_\_\_\_

Mobile Ph: \_\_\_\_\_

Plan prepared by:

Dr: \_\_\_\_\_

I hereby authorise medications specified on this plan to be administered according to the plan.

Signed:

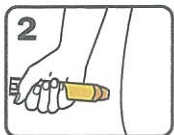
Date: \_\_\_\_\_

Date of next review: \_\_\_\_\_

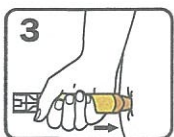
## How to give EpiPen®



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE.



PLACE ORANGE END against outer mid-thigh (with or without clothing).



PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds.

REMOVE EpiPen®. Massage injection site for 10 seconds.

Instructions are also on the device label and at: [www.allergy.org.au/anaphylaxis](http://www.allergy.org.au/anaphylaxis)

## MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

## ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy, flick out sting if visible. Do not remove ticks.
- Stay with person and call for help.
- Locate EpiPen® or EpiPen® Jr adrenaline autoinjector.
- Give other medications (if prescribed).....
- Phone family/emergency contact.

**Mild to moderate allergic reactions may not always occur before anaphylaxis**

**Watch for ANY ONE of the following signs of anaphylaxis**

## ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)

## ACTION FOR ANAPHYLAXIS

- 1 Lay person flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.**
- 2 Give EpiPen® or EpiPen® Jr adrenaline autoinjector.**
- 3 Phone ambulance\*: 000 (AU) or 111 (NZ).**
- 4 Phone family/emergency contact.**
- 5 Further adrenaline doses may be given if no response after 5 minutes, if another adrenaline autoinjector is available.**

### If in doubt, give adrenaline autoinjector

**Commence CPR at any time if person is unresponsive and not breathing normally.**

EpiPen® is generally prescribed for adults and children over 5 years.

EpiPen® Jr is generally prescribed for children aged 1-5 years.

\*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

## IF UNCERTAIN WHETHER IT IS ANAPHYLAXIS OR ASTHMA

- Give adrenaline autoinjector FIRST, then asthma reliever.
- If someone with known food or insect allergy suddenly develops severe asthma like symptoms, give adrenaline autoinjector FIRST, then asthma reliever.

Asthma: Y  N  Medication: \_\_\_\_\_

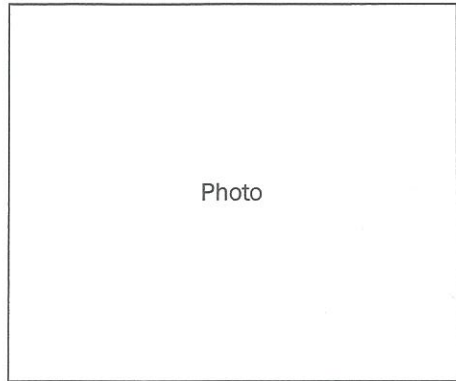


# ACTION PLAN FOR Anaphylaxis

Name: \_\_\_\_\_

For use with Anapen® adrenaline autoinjectors

Date of birth: \_\_\_\_\_



Photo

Confirmed allergens:

Family/emergency contact name(s):

Work Ph: \_\_\_\_\_

Home Ph: \_\_\_\_\_

Mobile Ph: \_\_\_\_\_

Plan prepared by:

Dr: \_\_\_\_\_

I hereby authorise medications specified on this plan to be administered according to the plan.

Signed:

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

Date of next review: \_\_\_\_\_

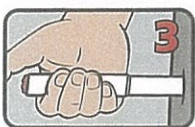
## How to give Anapen®



PULL OFF BLACK NEEDLE SHIELD.



PULL OFF GREY SAFETY CAP from red button.



PLACE NEEDLE END FIRMLY against outer mid-thigh at 90° angle (with or without clothing).



PRESS RED BUTTON so it clicks and hold for 10 seconds. REMOVE Anapen® and DO NOT touch needle. Massage injection site for 10 seconds.

Instructions are also on the device label and at: [www.allergy.org.au/anaphylaxis](http://www.allergy.org.au/anaphylaxis)

## MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

## ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy, flick out sting if visible. Do not remove ticks.
- Stay with person and call for help.
- Locate Anapen®300 or Anapen®150 adrenaline autoinjector.
- Give other medications (if prescribed).....
- Phone family/emergency contact.

**Mild to moderate allergic reactions may not always occur before anaphylaxis**

Watch for **ANY ONE** of the following signs of anaphylaxis

## ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)

## ACTION FOR ANAPHYLAXIS

- 1 Lay person flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.**
- 2 Give Anapen®300 or Anapen®150 adrenaline autoinjector.**
- 3 Phone ambulance\*: 000 (AU) or 111 (NZ).**
- 4 Phone family/emergency contact.**
- 5 Further adrenaline doses may be given if no response after 5 minutes, if another adrenaline autoinjector is available.**

### If in doubt, give adrenaline autoinjector

Commence CPR at any time if person is unresponsive and not breathing normally.

Anapen®300 is generally prescribed for adults and children over 5 years.

Anapen®150 is generally prescribed for children aged 1-5 years.

\*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

## IF UNCERTAIN WHETHER IT IS ANAPHYLAXIS OR ASTHMA

- Give adrenaline autoinjector FIRST, then asthma reliever.
- If someone with known food or insect allergy suddenly develops severe asthma like symptoms, give adrenaline autoinjector FIRST, then asthma reliever.

Asthma: Y  N  Medication: \_\_\_\_\_



24 October 2012

Dear Parent/Guardian,

To help us provide the best asthma care for your child, please complete the attached Asthma Record if your child has been diagnosed with asthma. This form should be completed in consultation with your child's doctor and as quickly as possible to us.

To keep our records up to date please send us written advise of any changes to your child's asthma management or request an additional copy of the Asthma Record.

At the time you return the Asthma Record, please demonstrate how to administer your child's medication.

If there is no Asthma Record provided for your child's asthma management, staff who have been trained in Emergency Asthma Management will use the standard Asthma First Aid Plan as detailed in our Asthma Policy if your child has been known to have asthma or is having difficulty breathing.

Services have policies and procedures for managing medical emergencies including when an ambulance is called. We encourage you to have ambulance cover for your child.

If you would like any further information about asthma management, please contact the Asthma Foundation NSW on 1800 645 130 or visit [www.asthmansw.org.au](http://www.asthmansw.org.au).

If you have any queries regarding this matter, please contact our College on 9809 4894.

Yours sincerely

Mrs C Norris  
Principal

Mrs J Thorn  
Senior First Aid Officer

## Child Asthma Record

This form is to be completed by parents/carers in consultation with the child's doctor (general practitioner or specialist). Parents/carers should inform the service immediately if there are any changes to the child's asthma management. A new Asthma Record should be provided at the beginning of each year. Please tick the appropriate box, and print your answers clearly in the blank spaces where indicated.

### Personal Details

Child's Name \_\_\_\_\_ (first name) \_\_\_\_\_ (last name)

Gender  Male  Female Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_

Name of Children's Service \_\_\_\_\_

Emergency Contacts (e.g. Parent or carer) 1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Telephone (Daytime) \_\_\_\_\_ (Home) \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Telephone (Daytime) \_\_\_\_\_ (Home) \_\_\_\_\_

Doctor's Contact Details Name \_\_\_\_\_ Telephone \_\_\_\_\_

### Asthma Management Plan

Does the child tell the carer when he/she needs medication?  Yes  No

Child's Symptoms (eg cough) \_\_\_\_\_

Triggers (eg exercise, pollens) \_\_\_\_\_

Medication Requirements: (Parents need to supply asthma medication eg, puffer and spacer)

Name of Medication	Method of delivery (eg puffer & spacer)	When and how much?

In an EMERGENCY, follow the Plan below that has been ticked

**Standard Asthma First Aid Plan**

Step 1: Sit the child upright and remain calm and provide reassurance. Do not leave the child alone.

Step 2: Give 4 puffs of a blue reliever (Airomir, Asmol, Epaq or Ventolin), one puff at a time, through a spacer device\*. Ask the child to take 4 breaths from the spacer after each puff.

Step 3: Wait 4 minutes.

Step 4: If there is little or no improvement, repeat steps 2 and 3. If there is still little or no improvement, call an ambulance immediately (Dial 000). Continue to repeat steps 2 and 3 while waiting for the ambulance.

\*Use a blue reliever (Airomir, Asmol, Epaq or Ventolin) on its own if no spacer is available.

**My Child's Asthma First Aid Plan**  
as written in consultation with my child's doctor.

(full details must be attached or staff will use the above Standard Asthma First Aid Plan)

Additional Comments: \_\_\_\_\_

I authorise the staff at the service to follow the preferred Asthma First Aid Plan and assist my child with taking asthma medication should he/she require help. I will notify you in writing if there are any changes to these instructions. Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms whilst attending the service.

Signature of Parent/Carer \_\_\_\_\_ Date \_\_\_\_\_

Signature of Child's Doctor \_\_\_\_\_ Date \_\_\_\_\_



## Long term medication authority

(This Medication Authority is to be completed for each medication administered on a long term basis. A new form should be completed each semester medication is required, or if medication varies.)

Date: - Week commencing: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Dosage and Doctor's instructions relating to administration: \_\_\_\_\_

Time span for medication: From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Time(s) for medication to be administered: \_\_\_\_\_ am/pm \_\_\_\_\_ am/pm

Name of Prescribing Doctor: \_\_\_\_\_ Telephone : \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

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

Staff Name: \_\_\_\_\_

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

**(STAFF USE ONLY)**

Date: \_\_\_\_\_ Time medication administered: \_\_\_\_\_ am/pm

Dosage administered : \_\_\_\_\_

Name of administering staff member: \_\_\_\_\_

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

Name of witness to medication: \_\_\_\_\_

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

Date: \_\_\_\_\_ Time medication administered: \_\_\_\_\_ am/pm

Dosage administered : \_\_\_\_\_

Name of administering staff member: \_\_\_\_\_

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

Name of witness to medication: \_\_\_\_\_

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

**Privacy Notice**

The information provided by you on this form will be used by Ryde Secondary College for the purposes of general administration. The information is essential for the care of your child .

The information provided will be held securely and disposed of securely when no longer needed. You may correct any personal details by contacting our College.

## Short-term Illness medication authority

(This Medication Authority is to be completed for each medication administered on a long term basis. A new form should be completed each semester medication is required, or if medication varies.)

Date: - Week commencing: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Dosage and Doctor's instructions relating to administration: \_\_\_\_\_

Time span for medication: From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Time(s) for medication to be administered: \_\_\_\_\_ am/pm \_\_\_\_\_ am/pm

Name of Prescribing Doctor: \_\_\_\_\_ Telephone : \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

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

Staff Name: \_\_\_\_\_

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

**(STAFF USE ONLY)**

Date	Date	Date	Date
Dosage Administered			
Time Medication Administered	am	am	am
	pm	pm	pm
Staff member administering			
Signature			
	Date:	Date:	Date:

**Privacy Notice**

The information provided by you on this form will be used by Ryde Secondary College for the purposes of general administration. The information is essential for the care of your child .

The information provided will be held securely and disposed of securely when no longer needed. You may correct any personal details by contacting our College.



