

# Medication Agreement



**CONFIDENTIAL**

This information is confidential and will be available only to relevant staff and emergency medical personnel. *Medication Agreements that are modified, overwritten or illegible will **NOT** be accepted.*

The legal guardian must complete the medication agreement authorising staff to administer medication as instructed. All sections of the 'Authorisation' section must be checked to confirm authorisation to administer the medication at school, by the legal guardian. *A member of staff may assist the legal guardian to complete this form.*

The 'Agreement' **must** be completed where pain relievers (paracetamol or ibuprofen), are required to be administered regularly or for more than 72 continuous hours.

## PARENT OR GUARDIAN TO COMPLETE:

School:	Wundowie Primary School		
Student:		Year:	
Teacher:		Form:	
Date of birth:		Date of next review:	
Allergies:			
<b>MEDICATION INSTRUCTIONS</b>			
<i>The medication instructions must match EXACTLY the pharmacy label on the medication or medication will not be administered</i>			
Medication name		<b>TIME(S)</b> <i>To be administered within ½ hour of specified time(s):</i>	
Form ( liquid, tablet, capsule, lotion, oxygen, inhaler, injection)	Route (skin, oral, inhaled, gastrostomy, subcutaneous)		
Strength (mg or mg/ml)	Dose (the number of tablets or mls must be written)	Start date:	
Other instructions for administration (when not appropriate to administer; how to administer i.e. with food; any changes to medication prior to administration i.e. crushing)		End date: <i>Medication Agreement ceases to be valid as at this date. Not required for long term medication.</i>	
<b>AUTHORISATION AND RELEASE</b>			
<input type="checkbox"/>	The medication documented above is required to be administered during attendance at the school.		
<input type="checkbox"/>	The medication documented above is NOT a pain relief that requires administration for more than 72 continuous hours (if it is yes, 'Agreement' section must be completed by a health professional).		
<input type="checkbox"/>	Where the medication is a prescription medication; the medication has been prescribed for a current health condition.		
<input type="checkbox"/>	I confirm this medication has been administered to my child previously (a first dose cannot be administered at the school).		
<input type="checkbox"/>	My child is well enough for school (no active fever, no diarrhea or vomiting, able to eat and drink as per normal, enough energy to participate throughout the day) and if there is a change in my child's health condition I will be called to collect them.		
<input type="checkbox"/>	I understand the medication provided must have a pharmacy label that matches the information in the Medication Agreement or the medication will not be administered.		
<input type="checkbox"/>	I approve the release of this information to supervising staff and emergency personnel (if required).		
<input type="checkbox"/>	I authorise the medication as instructed above to be administered by staff.		
<input type="checkbox"/>	I certify the above statements are true and correct.		
Legal guardian/ or adult student/client _____			
<small>First name (please print)</small>		<small>Family name (please print)</small>	
Signature:			Date:

<b>AGREEMENT: SCHOOL TO COMPLETE</b> (must complete for pain relief required to be administered regularly or for more than 72 hours)		
	I agree the medication instructions as written above are appropriate for administration at school	
	I authorise staff at Wundowie Primary School to administer said pain relief	
<i>(school stamp)</i>	Date	
	Role	
	Signature	