Interim 24 Hour Parental Authorised Medication For education, childcare and community support services

**PARENT AUTHORISED MEDICATION WILL ONLY BE ADMINISTERED FOR A MAXIMUM OF 24**

**HOURS (WITHIN A 4 WEEK PERIOD) WITHOUT MEDICAL PRACTITIONER AUTHORITY**

**CONFIDENTIAL**

**To be completed by the PARENT/GUARDIAN and/or ADULT STUDENT**

This information is confidential and will be available only to supervising staff and emergency medical personnel

**Interim 24 hour medication authorisation from parent/guardian**: A parent/guardian can provide written authorisation for medications to be administered in schools/childcare for a **maximum of 24 hours**. **This authority can be used where it is not possible to get an appointment with the treating health practitioner within this timeframe.** This authority can be used for prescription and non-prescription medications which meet DECD policy (ie provided in original pharmacy labelled container for a specific child/student)

This authority **cannot be used for commencement of a new medication that the child/student has not previously taken.** If used for non-prescription medication, staff will only administer against recommended doses on the original packaging. **This authority should not be accepted for medication to be given during a planned event (eg excursion/overnight trip etc) where parents/guardians should get a Medication Authority signed by the child/student’s treating health practitioner.**

Name of child/student

Date of Birth \_

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| **MEDICATION INSTRUCTIONS**  *(please print clearly)* | **TIME**  *Tick administration time(s)* |
| Medication name *(Generic name on original packaging – not brand name)* |  8.30 – 10.00am   10.30 – 12 noon   12.30 – 1.00pm   1.30 – 3.15pm   Other *(please specify)* |
| Form *(e.g. liquid, tablet, capsule, cream)* |
| Route *(e.g. oral, inhaled, skin)* |
| Strength *(included on original packaging)* |
| Dose *(as advised on pharmacy label or recommended on packaging)* |
| Other instructions - if to be given for specific signs/symptoms – state clearly |
| Any difficulties with administration (eg coordinating a puffer and spacer) |

**Parent / guardian / adult student:**

***I have read, understood and agreed with this plan and any attachments indicated above. I approve***

***the release of this information to supervising staff and emergency medical personnel.***

Family name (please print) First name (please print) Signature Dat

**School / Childcare authorised staff person:**

Start Date: Finish Date (48 hrs only):

Family name (please print) First name (please print) Signature Date

Medication authority short-term October 2013