ADMINISTRATION OF MEDICATION AUTHORISATION
Form A
(Parent/ Guardian)

Larmenier
Catholic Primary School

Use this form to provide authorisation to the 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 B (Doctor/Pharmacist/Practice Nurse)" (found over page).
c. Allow your child to **self-administer their prescribed** medication.

Student's Name	Surname or family name	
	First Name	Second Name
Medication to be given to student during school hours, as prescribed/ authorised by the student's medical practitioner/pharmacist/ practice nurse	Name of medication	
	Expiry Date	
	Dose and route (by mouth, etc)	
	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 school immediately of any changes to the details above.

ADMINISTRATION OF PRESCRIBED MEDICATION AUTHORISATION
Form B
(Doctor/Pharmacist/Practice Nurse)

Larmenier
Catholic Primary School

Use this form to provide authorisation to the school to
a. Administer **prescribed** medication to the child named on the form.
b. Allow the child named on the form to **self-administer their prescribed** medication.

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

Student's Name	Surname or family name First Name Second Name
Oral Medication to be given to student during school hours.	Name of medication
	Type of medication (eg S8, S4d)
	Dose and route (by mouth, etc)
	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
Epi-Pen treatment to be given to student when signs/symptoms occur during school hours after known or suspected exposure	Student has a severe allergic reaction to
	Allergic reaction is a result of the student being exposed to
	The following signs/symptoms result from exposure to the allergen
	Name of medication
	Expiry date
	Dose and route (by mouth, etc)
	Frequency
Signature Please circle relevant profession Doctor Pharmacist Practice Nurse	Name (please print)
	Address
	Signature
	Date

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