Consent to Administer Supplied Medication

For medication to be administered to students when they are attending College or during College-related activities, there must be parent/caregiver consent as well as medical authorisation for the student to have that medication (Refer Administration of Medication Procedure).

Please make an appointment with the Head of Campus or First Aid Officer if:

- the student requires medication as an emergency response;
- you would like the student to self-administer their medication;
- the student has complex health support needs or requires other support strategies;
- you have any concerns about the student's health which may affect their schooling.

To request that the College administer supplied medication to a student

1. Complete **Section A**
2. Provide the College with the medication in its original container or DAA with intact internal packaging.
3. Provide the required written medical authorisation (ie. completed pharmacy label, medication order, prescribing health practitioners letter, health plan)

Note: If your child is to take more than one medication, please complete a separate form for each medication.

To request a Student self-administer their medication

1. Complete **Section A** and **Section B**
2. Written advice provided by the prescribing health practitioner

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PRINCE of PEACE LUTHERAN COLLEGE

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Section A: ***Complete the details below:*** NOTE: This form only collects information for one (1) medication.

Student Full name				**Date of birth**	
Campus		**Year Level**		**Class/PC Class**	
Parent/caregiver name				**Mobile Ph #**	
Relationship to Student			**Email**		

- I consent to the following medication being administered (as per the instructions on the pharmacy label and/or any additional written instructions) to the student named above during College or College-related activities.
- I authorise College staff to contact the prescribing health practitioner or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication to this student.

Name of medication:	
Dosage to be given at school:	

I confirm that the medication provided to the College (as listed above): Please ✓

☐ is medically authorised *(e.g. has been prescribed by a doctor, dentist, optometrist or nurse practitioner)*
☐ is in the original dispensed container (or DAA) with intact internal packaging
☐ has the student and doctor's name on the pharmacy label *(if there is no other written medical authority)*
☐ is current/in-date *(*The expiry date of the medication is _ _ / _ _ / _ _ _ _*).*

The medication is required: Please ✓		If **Yes** to any questions, complete the following:
(a) routinely (e.g. 11am every day)	☐ **No** ☐ **Yes⇨**	Administer at **_ _: _ _ am/pm (circle)** on the following days: *(circle the day/s required)* **Monday Tuesday Wednesday Thursday Friday**
(b) for a short time only (e.g. only for 2 weeks)	☐ **No** ☐ **Yes⇨**	Start date: _ _ /_ _ / _ _ _ _ End date: _ _ /_ _ / _ _ _ _
(c) to manage a health condition by following a current action plan or health plan provided	☐ **No** ☐ **Yes⇨**	Is the medication for: ✓ ☐ asthma ☐ anaphylaxis ☐ diabetes ☐ epilepsy ☐ cystic fibrosis ☐ other *(describe)* _____ ☐ I have provided the action or health care plan as required
(d) 'as needed' to treat minor or non-emergency symptoms	☐ **No** ☐ **Yes⇨**	☐ I understand that before the College administers this medication, if they are not aware of when this medication was most recently given to this student, I will be contacted to provide this information.

Has this student previously shown any side effects after taking this medication? Please ✓	**Yes ☐ No ☐**

If **Yes**, describe: _____

Additional Comments:			
Parent/Caregiver signature		**Date**	

If the student is to self-administer this medication, also complete **Section B**

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Consent to Administer Supplied Medication

OFFICE USE ONLY

I confirm the medication received and medical authorisation submitted match	**First Aid Officer Signature**	**Date**
This consent and associated documentation has been saved in the Student's electronic record	**Name & Initials**	**Date**
Approval has been granted by Head of Campus for self-administration of medication ☞ attach Risk Assessment for medication self-administration	**Head of Campus Signature**	**Date**
Comments:		

Office Only: Retain a physical copy with the medication and a digital copy of this form in the student's health centre record

Privacy Statement

Prince of Peace Lutheran College is collecting this personal information for the purpose of enabling staff to administer medication to the nominated student, or to support a student to self-administer their medication while at College or during College-related activities. This information will only be accessed by authorised persons. In accordance with section 426 of the *Education (General Provisions) Act 2006* (regarding student's personal information) and the *Information Privacy Act 2009* (parent/carer's personal information) this information will not be disclosed to any other person or body unless the College has been given permission or is required or authorised by law to disclose the information.

PRINCE of PEACE LUTHERAN COLLEGE

Consent to Administer Supplied Medication

Section B*: ONLY COMPLETE TO REQUEST student self-administration of medication:*
NOTE: Schedule 8 medication cannot be self-administered.

In all cases and at any time, the Head of Campus/delegate may disallow student self-administration for health and/or safety reasons.

Student name		**Date of birth**	

- I confirm that the student is confident, competent and can safely administer the right dose of their own medication at the right times, as supported by the written advice provided by the prescribing health practitioner.
  - ☐ Written Advice Attached ✓
- I confirm that the student can store their medication securely and in suitable storage.
- I authorise College staff to contact the prescribing health practitioner, health team or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication by this student.

Health condition	I seek approval from the Head of Campus for the student to self-administer:	Plan attached? ✓
☐ Asthma	☐ their asthma puffer (following a current asthma action plan)	
☐ Anaphylaxis	☐ their adrenaline auto-injector *(following a current action plan)*	
☐ Diabetes	☐ their medication *(following a current health care plan)*	
☐ Cystic fibrosis	☐ their medication *(following a current health care plan)*	
☐ Other _____	☐ their medication *(following a current health care plan)*	

Parent/caregiver signature		**Date**	

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