Medication plan

for schools, preschools and childcare services

CONFIDENTIAL

To be completed by the PRESCRIBING DOCTOR and the PARENT/GUARDIAN/ADULT STUDENT for a child or student who requires supervision of medication at school, preschool or while in sessional care.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

To the doctor

Please:

- *Complete all sections of this form.*
- *Schedule medication outside care/school hours wherever possible.*
- *Be specific: **As needed** is **not** sufficient direction for staff members—they need to know exactly when medication is required.*
- *Nominate the simplest method. **For example: Oral or 'puffer' medication is much easier to arrange than a nebuliser.***

Please note that education and childcare workers:

- *accept only medication which has been ordered by a doctor and is provided in the original, fully labelled pharmacy container*
- *do not monitor the effects of medication as they have no training to do this*
- *are instructed to seek emergency medical assistance if concerned about a child's/student's behaviour following medication.*

Name of child/student ..... Date of birth .....
Family name (please print) First name (please print)

Medic Alert number (if relevant) ..... Review date .....

MEDICATION INSTRUCTIONS *(Please print clearly)*	**TIME** *(Please indicate times relevant to schooling/child care)*
Medication name and form *(eg liquid, capsule, ointment)*	☐ Early morning ☐ Mid-morning ☐ Middle of the day ☐ Mid-afternoon ☐ Evening ☐ Other (please specify)
Dose	
Route *(eg oral or inhaled)*	
Any other instruction	

Please note:

- *Young children (eg junior primary age) are generally supervised when they take their oral/puffer medication*
- *Wherever possible, safe self-management is encouraged.*

Please advise if this child's/student's condition creates any difficulties with self-management; for example, difficulty remembering to take medication at a specified time or difficulties coordinating equipment (eg puffer and spacer).

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AUTHORISATION AND RELEASE

Medical practitioner ..... Professional role .....

Address .....

..... Telephone .....

Signature ..... Date .....

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

Parent/guardian
or adult student ..... Signature ..... Date .....
Family name (please print) First name (please print)