

Consent to administer medication

PLEASE NOTE:

For medication to be administered at school or during school-related activities, there must be medical authorisation for the student to have that medication, and the medication must be in its original container with intact packaging.

Examples of medical authorisation include:

- a pharmacy label with both the student's and doctor's name on it;
- a signed letter from a doctor;
- a medication order from a dentist;
- an Action Plan signed by a doctor or nurse practitioner.

See below for examples of health conditions, medications and associated documentation:

Health condition/ reason for medication	Example of medication	Documentation completed by doctor or other prescribing health practitioner
Asthma	Asthma puffer	<i>Asthma action plan</i>
Anaphylaxis	EpiPen	<i>ASCIA Anaphylaxis Action Plan</i>
Diabetes	Insulin injection, insulin pump	Department of Education <i>Medication order to administer 'as-needed' medication at school</i> or medication order or <i>diabetes management plan</i> or other written instructions from prescribing health practitioner
Other types of emergency medication e.g. for seizures	Midazolam	Department of Education <i>Medication order to administer 'as-needed' medication at school</i>
Medication required 'as needed' for minor or non-emergency symptoms	Ointment for skin allergies, antihistamines	Department of Education <i>Medication order to administer 'as-needed' medication at school</i>
Changes to dosage (e.g. from ½ to 1 tablet)	Ritalin	Written instructions from prescribing health practitioner (e.g. doctor)

1. To request that the school administer medication to a student

- 1) Complete Section A (page 2).
- 2) Provide the school with the medication in the original container with intact packaging.
- 3) Provide the written medical authorisation (e.g. completed pharmacy label, medication order, action plan) completed and signed by the prescribing health practitioner.
- 4) Make an appointment with the principal/delegate 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; or
 - you have any concerns about the student's health which may affect their schooling.

2. To request a student self-administer their medication

- 1) Complete Section A (page 2) and Section B (page 3).

Consent to administer medication

Privacy Statement

The Department of Education (DoE) is collecting this personal information for the purpose of enabling school staff to administer medication to the nominated student, or to support a student to self-administer their medication while at school or during school-related activities. This information will only be accessed by authorised departmental employees. 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 DoE has been given permission or is required or authorised by law to disclose the information.

Section A: Complete the details below:

NOTE: This form only collects information for one (1) medication. If more than one medication is required, please complete a separate form for each medication.

Student name		Date of birth	
Parent/carer name		Phone number	

- 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 school or school-related activities.
- I authorise school 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	
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I confirm that the medication provided to the school (as listed above):

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

The medication is required:		If Yes to any questions, complete the following:
(a) routinely (e.g. 11am every day)	<input type="checkbox"/> No <input type="checkbox"/> Yes⇒	Administer at __: __ am/pm 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)	<input type="checkbox"/> No <input type="checkbox"/> Yes⇒	Start date: __/__/____ End date: __/__/____
(c) to manage a health condition by following a current action plan or health plan	<input type="checkbox"/> No <input type="checkbox"/> Yes⇒	Is the medication for: <input type="checkbox"/> asthma <input type="checkbox"/> anaphylaxis <input type="checkbox"/> diabetes <input type="checkbox"/> epilepsy <input type="checkbox"/> cystic fibrosis <input type="checkbox"/> other (describe)
(d) 'as needed' to treat minor or non-emergency symptoms	<input type="checkbox"/> No <input type="checkbox"/> Yes⇒	<input type="checkbox"/> I understand that before the school 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? Yes No

If Yes, describe: _____

Parent/carer/student signature		Date	
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If the student is to self-administer this medication, also complete **Section B**

NOTE: Controlled drugs cannot be self-administered.

Section B: Details for student self-administration of medication:			
<i>In all cases and at any time, the principal/delegate may disallow student self-administration for health and/or safety reasons.</i>			
Student name		Date of birth	
<ul style="list-style-type: none"> I confirm that the student is confident, competent and can safely administer the right dose of their own medication at the right times. I confirm that the student can store their medication securely. I authorise school 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			
<input type="checkbox"/> Asthma - secondary school students only	<input type="checkbox"/> I approve for the student to self-administer their asthma medication. NOTE: The school will need a copy of the student's <i>Asthma Action Plan</i> if it varies from the standard asthma first aid response		
Health condition	I seek approval from the principal/delegate for the student to self-administer:		
<input type="checkbox"/> Asthma	<input type="checkbox"/> their asthma medication (<i>following a current action plan/health plan</i>)		
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> their adrenaline auto-injector (<i>following a current action plan/health plan</i>)		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> their medication (<i>following a current health plan</i>)		
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> their medication (<i>following a current health plan</i>)		
<input type="checkbox"/> Other _____	<input type="checkbox"/> their medication (<i>following a current health plan</i>)		
Parent/carers/student signature		Date	

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Medication order to administer 'as-needed' medication at school

The following information will be used by Queensland state school staff to support the administration of 'as-needed' medication to the student named below at school or during school-related activities (e.g. camps, excursions).

Prescribing health practitioner to complete <u>all</u> sections below:			
Student name		Date of birth	
Medication		Dosage and route	
This medication is to be administered as: <i>(please select one or both)</i>			
<input type="checkbox"/> an emergency response		<input type="checkbox"/> a non-emergency response	
Administer the medication when these signs and symptoms occur:			
The maximum number of dosages allowed over a 24-hour period are:			
The minimum length of time allowed between dosages is:			
The expected response the student would have after having this medication administered is:			
If there is no response in approximately ____ minutes, take the following action [e.g. call ambulance]:			
Please note: The school will notify the parent/carer if the student displays any suspected side effects following administration.			
Please indicate if additional information is attached (if required): YES <input type="checkbox"/> NO <input type="checkbox"/>			
Name of prescribing health practitioner:		Medical practice stamp/sticker:	
Signature of prescribing health practitioner:			
Date:			
Review date of this medication order:			