



VERMONT SOUTH  
SPECIAL SCHOOL

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**2019 MEDICATION AUTHORITY FORM**

Name of Student.....

Date of Birth:.....

In order to provide the safest possible administration of your child’s medication during school hours, we ask you to complete this form. To ensure **no error** is made in tablet identification or dosage, your child’s medication must be sent to the school in the correctly labelled bottle supplied by the chemist.

Please note: School Staff **do not** monitor the effects of medication and will seek emergency medical assistance if concerned about a student’s behaviour following medication.

**Is this medication ongoing and required at school? No/Yes**

- If yes, please provide the following information.
- Please indicate if there are any specific storage instructions.

<u>Medication</u>	<u>Dosage</u>	<u>When &amp; How often</u>	<u>Supervision</u>	<u>Storage</u>
			Yes	
			Yes	
			Yes	

**Authorisation to administer medication according to this form**

I agree to my child,....., being given the medication listed above.

Parent/Guardian Signature: ..... Date: .....

**Doctor’s written order for above medication (to be completed by Doctor)**

.....  
.....

Doctor’s Signature: .....

Date: .....

Doctor’s Name (please print).....

Contact details:  
(Address & telephone)

We collect personal and health information to plan and support the health needs of our students. Information collected will be used and disclosed in accordance with the Departments of Education and Training’s policy which applies to all government school (available at <http://www.education.vic.gov.au/Pages/schoolsprivacypolicy.aspx>) and the law.