Prince Alfred College

Medication Authority

Confidential

To be completed by the Authorised Prescriber and/or the Parent / Guardian (if applicable)

Please Print Clearly

Name of Student:_____ Date of Birth:_____

Allergies:_____ Medic Alert Number (if relevant)_____

To the Medical Practitioner (or Authorised Prescriber):

MEDICATION	STRENGTH	ROUTE	DOSE	TIME		
				Morning	Lunch	Evening

Start Date:_____ Review Date:_____

Storage Considerations?:_____

Administration considerations?:_____

Potential side effects?:_____

Management of any side effects:_____

Do you consider it safe for the student to self-manage his medication if permitted to by the school?

Yes No

Any further comments?:_____

In my view, it is safe for school staff to assist in the administration of the above medication(s).

Authorised Prescriber (Please print name):_____

Signature:_____ Date:_____

Address:_____

For completion by Parent / Guardian:

I/we have requested the school staff to assist with the above medication(s). On behalf of the above named child I/we consent to this undertaking and release Prince Alfred College and the staff from any liability which may arise from undertaking this assistance. I/we understand it is my responsibility to ensure this information is updated as necessary. I/we approve the release of this information to supervising staff and emergency personnel.

Parent/Guardian name(s):_____ (Please Print)

Signature(s):_____ Date:_____