Administration of Prescribed Medication Authorisation
Form B (Doctor/Pharmacist/Practice Nurse)

- Use this form to provide authorisation to the school to
  a.) administer prescribed medication to the child named on the form
  b.) allow the child named *on the* form to self-administer prescribed medication.
- This form must be completed either by a doctor, or the pharmacist dispensing the medication or a practice nurse from the prescribing doctor's surgery.
- Please complete the appropriate sections.

Student's *Name*	Surname or family name First given name Second *given name* _____
Oral medication to be given to student during school hours.	Name of medication _____ Type of medication (eg S8, S4d) _____ Dose and route _____ Frequency _____ Relation to meals or n/a _____ Side effects, if any, school staff should be made aware of _____ Is the student permitted to self-administer this medication? Yes/No
EpiPen treatment to be given to student when sign/symptoms occur during school hours after known or suspected exposure.	Student has severe allergic reaction to: _____ Allergic reaction is a result of the student being exposed to: _____ The following signs/symptoms result from exposure: _____ Name of staff member/s to administer medication: _____ Name of medication _____ Expiry date _____ Dosage and route _____ Frequency _____
Signature Please circle relevant profession: Doctor Pharmacist Practice Nurse	Name (please print) Address Signature: _____ Date: _____

Important: Please notify school immediately of any changes to the details above.