Mount Waverley Secondary College

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Junior Campus: 145 Stephensons Road, Mount Waverley   T 9887 9290 F 9887 9231

MEDICATION AUTHORITY FORM FOR CAMPS & TOURS

Student Name:………………………………..………..…   Student Code:………………….…………

Date of Birth: ………………………………………..

Camp/Tour Name:………………………………………………………………………..

- Please complete this form and include it with any medication your child needs during camp.

- Medication must be given to the nurse or teacher in charge, on the morning your child leaves for camp.

- All medication must come in its original packaging in a zip lock bag with student name and medicine expiry date clearly visible.

Name of Medication:	
Dosage:	
To be taken *(e.g. orally, topically etc)*:	
Times (or 'as necessary'):	
Conditions to be treated by medication:	
I give permission for my child to self-administer this medication (Year 10-12 students only)	☐ YES ☐ NO

Name of Medication:	
Dosage:	
To be taken *(e.g. orally, topically etc)*:	
Times (or 'as necessary'):	
Conditions to be treated by medication:	
I give permission for my child to self-administer this medication (Year 10-12 students only)	☐ YES ☐ NO

Name of Medication:	
Dosage:	
To be taken *(e.g. orally, topically etc)*:	
Times (or 'as necessary'):	
Conditions to be treated by medication:	
I give permission for my child to self-administer this medication (Year 10-12 students only)	☐ YES ☐ NO

Parent/Carer Name:_____Contact No: _____
     (please print)

Parent/Carer Signature:_____Date: _____

RECORD OF ADMINISTRATION (*STAFF USE ONLY*)

Student's Name:……………………….….………………………..   Student Code:……..…….   Date of Birth: ……..……..

- Please complete this form when administrating medications

RECORD OF TIME GIVEN (For School Use Only)												
						Tick when checked						
Date	Time	Medication	Reason (symptoms, or scheduled)	Dose	Correct Child	Correct Medication	Correct Dose	Correct Route (eg: oral, topical, inhaled)	Number of tablets/capsules remaining (must be completed for Schedule 8 medications)	Staff member administering (print name and initial)	Staff member checking* (print name and initial)
EXAMPLE			e.g.: Headache, or scheduled medication	2 tablets, 50mgs	√	√	√	√	e.g. 18	Eliza Dolittle DEJ	Must be done if prescription medication, Schedule 8 medication

*Cross-checking: It is recognised that in many school settings medication is administered using a system of two staff members checking that medication is correctly administered. This is an appropriate added safety measure and is seen as good practice.