

Administration of medications in Queensland state schools: Information for parents/carers and health practitioners

This information sheet provides advice for parents/carers and their child's health practitioner/s regarding the documentation required for Queensland state schools to safely administer medication to students while they are at school or school-related activities.

All medications you provide for the school to administer to your child must be prescribed by a qualified health professional who is authorised to prescribe medications under the Health (Drugs and Poisons) Regulation 1996 (Qld) e.g. doctor, dentist, optometrist. State schools refer to these professionals as 'prescribing health practitioners' (practitioners).

A blank *Medication order to administer 'as-needed' medication at school* is provided on the last page.

For further information, refer to the [Administration of medications in schools procedure](#) and the [Managing student's health support needs at school procedure](#).

Information for parents/carers

1. For all medications

For medication to be administered during school hours and/or during school-related events, provide the school with:

- a completed [Consent to administer medication form](#).
- the medication with an attached pharmacy label, in its original container, with intact packaging.

2. Where no additional information is required from your practitioner

If your child requires medication at a routine time (e.g. 11am every day), the pharmacy label attached to the medication provides the school with the instructions from the doctor/dentist needed to safely administer the medication. Examples of routine medication include Ritalin, antibiotics, eye/ear drops, enzyme tablets and ointments.

No other written information from the prescribing health practitioner is required.

3. Where you will need additional written information from your practitioner

As well as using the pharmacy label instructions, the school will need additional written information from the prescribing health practitioner if your child:

- a. **requires medication as an emergency response.** Depending on your child's health condition, your doctor will need to complete:
 - an Asthma Action Plan and/or
 - an Anaphylaxis Action Plan and/or
 - written instructions if your child has more complex health needs.
- b. **requires insulin.** Your doctor will need to complete a medication order for insulin.
- c. **requires medication 'as-needed' (but not as an emergency response).** Your health practitioner will need to complete a *Medication order to administer 'as-needed' medication at school* (see page 3).
- d. **has their dosage changed from that on the pharmacy label.** Your health practitioner will need to write a letter for the school explaining the changes. To assist the school in safely administering the medication to your child, you are encouraged to have your pharmacist update the pharmacy label attached to the medication with the new dosage as soon as possible.

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 <input type="checkbox"/> No <input type="checkbox"/>
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/carer/student signature		Date	