Government of South Australia
Department for Education

Medication Agreement

for education and care

CONFIDENTIAL

This information is confidential and will be available only to relevant staff and emergency medical personnel.

The agreement section must be completed by a medical practitioner (GP or specialist), nurse practitioner, or pharmacist.

Authorisation/Release must be completed by the parent or legal guardian; or the adult student.

The authorisation/release and agreement sections must be completed for the medication to be administered in an education or care setting.

Medication Agreements that are modified, overwritten or illegible will **NOT** be accepted

UR / Client number:
(if relevant)

Name:

Address:

DOB:

Fill in or attach the patient label

Allergies:

Weight:

Medication name *(include generic name)*	Form *(liquid, tablet, capsule,, lotion)*	Strength *(mg or mg/ml)*	Route *(topical, enteral, oral or inhaled)*	Dose *(e.g. # tablets,ml)*	Time *To be administered within ½ hour of specified time:*	Other instructions for administration *(when not appropriate to administer; how to administer i.e. with food; any changes to medication prior to administration i.e. crushing)*	End date *Leave blank if medication is continuing and complete Review Date section*

AGREEMENT

I agree the medication instructions as written above are appropriate for administration in the education or care setting

I authorise delegation to the WCHN Access Assistant Program/RN Delegation of Care Program

Authorised Prescriber *(print name, role, address, telephone or stamp)*

Professional role	Provider number
Email or signature	Date

AUTHORISATION AND RELEASE

I authorise the medication as instructed above to be administered in the education or care setting

I approve the release of this information to supervising staff and emergency medical personnel

I understand the medication provided must have a pharmacy label that matches the information in the Medication Agreement or the medication will not be administered.

Parent/legal guardian or adult student/client

First name (please print) Family name (please print)

Email or signature	Date

REVIEW DATE *(Medication Agreements must be reviewed every 12 months; where there are no changes the Authorised Prescriber may update the review date below)*

Review Date

Review Date	Date	Print name & initial
Review Date	Date	Print name & initial
Review Date	Date	Print name & initial

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