*This form is developed in partnership and has co-ownership with the South Australian Department for Education and the Department for Health and Wellbeing, Women's and Children's Health Network*

Government of South Australia

# Medication Agreement

## for education and care

**CONFIDENTIAL**

HSP151

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

The legal guardian or adult student can complete the medication agreement authorising education and care staff to administer medication as instructed. All sections of the 'Authorisation' section must be checked to confirm authorisation to administer in an education or care service by the legal guardian or adult student. *A treating health professional may assist the legal guardian or adult student to complete this form.*

A registered health professional (ie medical consultant, specialist nurse, GP, Dentist) **must** complete the 'Agreement' section for any Controlled Drug (S8) (including morphine, dexamphetamine and codeine), where oxygen or insulin is required to be administered in education or care, or where 3 or more doses of pain relievers (paracetamol or ibuprofen) are required to be administered in education or care within one week. Where midazolam is prescribed this must be documented on an INM Medication Agreement HSP153 form.

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

### LEGAL GUARDIAN OR ADULT STUDENT TO COMPLETE:

| | | | |
|---|---|---|---|
| Education or care service: | | | |
| Education or care service email: (if known) | | | |
| Name of child or young person: | | | |
| Date of birth: | | Date of next review: | |
| Allergies: | | | |

**MEDICATION INSTRUCTIONS**

*The medication instructions must match EXACTLY the pharmacy label on the medication or medication will not be administered*

| | | |
|---|---|---|
| Medication name | | **TIME(S)** *To be administered within ½ hour of specified time(s):* |
| Form *( liquid, tablet, capsule, lotion, oxygen, inhaler, injection)* | Route *(skin, oral, inhaled, gastrostomy, subcutaneous)* | |
| Strength *(mg or mg/ml)* | Dose *(the number of tablets or mls must be written)* | Start date |
| 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 *Medication Agreement ceases to be valid as at this date. Not required for long term medication.* |

**AUTHORISATION AND RELEASE**

| | |
|---|---|
| ☐ | The medication documented above is required to be administered during attendance at the education or care service. |
| ☐ | The medication documented above is NOT a Controlled Drug (S8), oxygen, insulin or pain relief that requires administration more than three times in one week (if it is yes, 'Agreement' section must be completed by a health professional). |
| ☐ | Where the medication is a prescription medication; the medication has been prescribed for a current health condition. |
| ☐ | I confirm this medication has been administered to my child previously (a first dose cannot be administered in education or care). |
| ☐ | My child is well enough for school (no active fever, no diarrhea or vomiting, able to eat and drink as per normal, enough energy to participate throughout the day) and if there is a change in my child's health condition I will be called to collect them. |
| ☐ | 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. |
| ☐ | I approve the release of this information to supervising staff and emergency personnel (if required). |
| ☐ | I authorise the medication as instructed above to be administered in the education or care setting. |
| ☐ | I certify the above statements are true and correct. |

Legal guardian/
or adult student/client _____
First name (please print) Family name (please print)

Email or signature: Date:

**AGREEMENT: REGISTERED HEALTH PROFESSIONAL TO COMPLETE**
(must complete for Controlled Drugs (S8), oxygen, insulin or pain relief required to be administered 3x+ in one week)

| | |
|---|---|
| ☐ | 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 (if required) |

| | | |
|---|---|---|
| *(print name & practice/hospital or stamp)* | Date | |
| | Professional role | |
| Telephone | Email or signature | |

MEDICATION AGREEMENT
*Health Support Planning*