Government of South Australia

# 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.

**This is a single medication sheet;** use a separate form for each medication. All sections of the form must be completed.

*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:

| MEDICATION INSTRUCTIONS *(please print clearly)* | | |
|---|---|---|
| Medication name *(include generic name)* | | **TIME** *To be administered within ½ hour of specified time:* |
| Form *( liquid, tablet, capsule, lotion)* | Route *(topical, enteral, oral or inhaled)* | |
| Strength *(mg or mg/ml)* | Dose *(# tablets,ml)* | 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.* ** Leave blank if medication is continuing and complete Review Date section* |

**AGREEMENT** *(completed by medical practitioner (GP or specialist), nurse practitioner, or pharmacist)*

☐ ***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 relevant or required)***

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

**AUTHORISATION AND RELEASE** *(please print clearly)*

- ***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 | |

*A Review Date is NOT an expiry date. Where a review date has expired the Medication Agreement will still be considered valid until an updated form is received. A Medication Agreement only ceases to be valid if the End Date is expired.*