Government of South Australia
Department for Education

CONFIDENTIAL

HSP151

Medication Agreement

for education and care

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:	**Weight:**

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***

(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

REVIEW DATE *Medication Agreements must be reviewed every 12 months; where there are no changes the Authorised Prescriber (as detailed above) may update the review date below*		Review Date
Review Date	Date	Print name and sign
Review Date	Date	Print name and sign
Review Date	Date	Print name and sign

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.

MEDICATION AGREEMENT
Health Support Planning

This document has been developed by, and has co-ownership with the Department for Education and the Women's and Children's Health Network Disability Services; Access Assistant Program