Emmaus Christian College

2026 MEDICATION PLAN

CONFIDENTIAL

This information is confidential and will be available only to relevant staff and emergency medical personnel.
Medication Plans that are modified, overwritten or illegible will NOT be accepted.

ATTENTION: PARENT/GUARDIAN

- Please complete all relevant sections authorising education and care staff to administer medication as instructed.
- All sections of the "Parent/Guardian Authorisation and Release" must be ticked to confirm acknowledgement of statements and authorisation to administer in an education setting.
- Medication to be delivered to school by the parent/guardian and is kept secure in the First Aid Room.

Student Name: _____ **Class:** _____ **Date of Birth:** ____/_____/_____

Condition(s) requiring medication: _____

Allergies: _____

MEDICATION INSTRUCTIONS

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

MEDICATION NAME		**STRENGTH** *(mg or mg/ml)*
DOSE *(the number of tablets or mls must be written)*	**ROUTE** *(oral, topical, inhaled)*	**TIMES TO BE ADMINISTERED** *(to be administered within ½ hour of specified time)*
FORM *(liquid, tablet, capsule, lotion, inhaler)*		
OTHER INSTRUCTIONS *(how to administer: i.e.: with food or crushed with water, etc)*		
START DATE:	**END DATE:**	

PARENT/GUARDIAN AUTHORISATION AND RELEASE *(Please tick all relevant boxes)*

☐ The medications documented above are in **fully labelled pharmacy containers and have the child's details that match the information on this form above**.
☐ The medication documented above is NOT a Controlled Drug (S8), oxygen, insulin or pain relief that requires administration for more than 72 continuous hours (if yes, a Medication Plan for Controlled Drugs (S8) must be completed separately).
☐ Where the medication is a prescription medication, the medication has been prescribed for a current health condition.
☐ I confirm these medications have been administered to my child previously (the first dose can NOT be administered in an education or care setting).
☐ My child is well enough for school (no active fever, no diarrhea or vomiting in the past 24 hours) and if there is a change in my child's health condition I may be called to collect them.
☐ I approve the release of this information to supervising staff and emergency personnel (if required).
☐ I certify the above statements are true and correct, and confirm that I have read, understood and agreed with this plan and any attachments placed on the form above.
☐ I acknowledge that this Medication Plan must be renewed at the start of the school year or if there is a change.

Parent/Guardian Name:_____ **Signature:** _____**Date:** ___/___/_____