Emmaus Christian College

2026 MEDICATION PLAN
FOR CONTROLLED DRUGS (S8)

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 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, skin, inhaled, subcutaneous)*	**TIMES TO BE ADMINISTERED** *(to be administered within ½ hour of specified time)*
FORM *(liquid, tablet, capsule, lotion, oxygen, inhaler, injection)*		
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**.
- ☐ 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 (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) 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:** ___/___/_____

AGREEMENT: REGISTERED HEALTH PROFESSIONAL TO COMPLETE

Must complete for Controlled Drugs (S8), oxygen, insulin or any form of pain relief required to be administered regularly or for more than 72 continuous hours.

☐ I agree the medications as written above are appropriate for administration in the education or care setting.

(Please print name & practice/hospital or stamp)	Date	
	Professional Role	
	Email/Signature	