



# 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.**

|   |       |
|---|-------|
| <b>UR / Client number:</b><br>(if relevant) | _____ |
| <b>Name:</b>                                | _____ |
| <b>Address:</b>                             | _____ |
| <b>DOB:</b>                                 | _____ |
| <i>Fill in or attach the patient label</i>  |       |

|                   |                |
|-------------------|----------------|
| <b>Allergies:</b> | <b>Weight:</b> |
|-------------------|----------------|

| MEDICATION INSTRUCTIONS<br><i>(please print clearly)</i>   |  |   |
|--|--|---|
| Medication name <i>(include generic name)</i>  |  | <b>TIME</b><br><i>To be administered within ½ hour of specified time:</i>   |
| Form <i>(liquid, tablet, capsule, lotion)</i>  | Route <i>(topical, enteral, oral or inhaled)</i> |   |
| Strength <i>(mg or mg/ml)</i>  | Dose <i>(# tablets,ml)</i>                       | Start date  |
| Other instructions for administration <i>(when not appropriate to administer; how to administer i.e. with food; any changes to medication prior to administration i.e. crushing)</i> |  | End date*<br><i>Medication Agreement ceases to be valid as at this date.</i><br><small>* Leave blank if medication is continuing and complete Review Date section</small> |

| AGREEMENT <i>(completed by medical practitioner (GP or specialist), nurse practitioner, or pharmacist)</i>  |                    |       |
|---|--------------------|-------|
| <ul style="list-style-type: none"> <li><b>I agree the medication instructions as written above are appropriate for administration in the education or care setting</b></li> <li><b>I authorise delegation to the WCHN Access Assistant Program/RN Delegation of Care Program</b></li> </ul> |                    |       |
| <i>(print name &amp; practice/hospital or stamp)</i>  | Professional role  | _____ |
|   | Provider number    | _____ |
|   | Email or signature | _____ |
| Telephone   | Date               | _____ |

| AUTHORISATION AND RELEASE <i>(please print clearly)</i>   |       |
|---|-------|
| <ul style="list-style-type: none"> <li><b>I authorise the medication as instructed above to be administered in the education or care setting</b></li> <li><b>I approve the release of this information to supervising staff and emergency medical personnel</b></li> <li><b>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.</b></li> </ul> |       |
| Parent/legal guardian/<br>or adult student/client _____   |       |
| _____   | _____ |
| _____   | _____ |
| _____   | _____ |
| _____   | _____ |

| REVIEW DATE  |      | Review Date         |
|--|------|---------------------|
| <i>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</i> |      |                     |
| 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.