



# 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> (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>
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MEDICATION INSTRUCTIONS <i>(please print clearly)</i>		
Medication name <i>(include generic name)</i>		<b>TIME</b> <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* <i>Medication Agreement ceases to be valid as at this date.</i> <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>I agree the medication instructions as written above are appropriate for administration in the education or care setting</li> <li>I authorise delegation to the WCHN Access Assistant Program/RN Delegation of Care Program</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>I authorise the medication as instructed above to be administered in the education or care setting</li> <li>I approve the release of this information to supervising staff and emergency medical personnel</li> <li>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.</li> </ul>	
Parent/legal guardian/ or adult student/client _____	
<small>First name (please print)</small>	<small>Family name (please print)</small>
Email or signature	Date

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.

