

Consent to administer medication to a child/ren form

PLEASE NOTE:

For medication to be administered on UQ Sport Ltd (UQSL) premises, there must be medical authorisation for the child/ren to have that medication, and the medication must be in its original container with intact packaging.

Examples of medical authorisation include:

- a pharmacy label with both the child's and doctor's name on it;
- a signed letter from a doctor;
- a medication order from a dentist;
- an Action Plan signed by a doctor or nurse practitioner.

See below for examples of health conditions, medications and associated documentation:

Health condition/ reason for medication	Example of medication	Documentation completed by doctor or other prescribing health practitioner
Asthma	Asthma puffer	<i>Asthma action plan</i>
Anaphylaxis	EpiPen	<i>ASCIA Anaphylaxis Action Plan</i>
Diabetes	Insulin injection, insulin pump	Medication order or <i>diabetes management plan</i> or other written instructions from prescribing health practitioner
Other types of emergency medication e.g. for seizures	Midazolam	Medication order to administer 'as-needed' medication
Medication required 'as needed' for minor or non-emergency symptoms	Ointment for skin allergies, antihistamines	Medication order to administer 'as-needed' medication
Changes to dosage (e.g. from ½ to 1 tablet)	Ritalin	Written instructions from prescribing health practitioner (e.g. doctor)

1. To request that UQ Sport administer medication to a child/ren

- 1) Complete Section A (page 2).
- 2) Provide UQSL with the medication in the original container with intact packaging.
- 3) Provide the written medical authorisation (e.g. completed pharmacy label, medication order, action plan) completed and signed by the prescribing health practitioner.
- 4) Please contact the Kids Holiday Camp Coordinator if:
 - your child/ren requires medication as an emergency response;
 - you would like your child/ren to self-administer their medication;
 - Your child/ren has complex health support needs or requires other support strategies.

2. To request a child/ren self-administer their medication

- 1) Complete Section A (page 2) and Section B (page 3).

Consent to administer medication

Privacy Statement

UQSL is collecting this personal information for the purpose of enabling UQSL staff to administer medication to the nominated child/ren, or to support a child/ren to self-administer their medication while on the premises. This information will only be accessed by authorised UQSL employees. In accordance with the *Information Privacy Act 2009* (parent/carer's personal information) this information will not be disclosed to any other person or body unless UQSL has been given permission or is required or authorised by law to disclose the information.

Section A: Complete the details below:

NOTE: This form only collects information for one (1) medication. If more than one medication is required, please complete a separate form for each medication.

Child name		Date of birth	
Parent/carer name		Phone number	

- I consent to the following medication being administered (as per the instructions on the pharmacy label and/or any additional written instructions) to my child named above while on UQSL premises.
- I authorise UQSL staff to contact the prescribing health practitioner or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication to this child.

Name of medication	
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I confirm that the medication provided to UQSL (as listed above):

- is medically authorised (e.g. has been prescribed by a doctor, dentist, optometrist or nurse practitioner)
- is in the original dispensed container with intact packaging
- has the child's and doctor's names on the pharmacy label (if there is no other written evidence of medical authorisation)
- is current/in-date (The expiry date of the medication is __/__/____).

The medication is required:		If Yes to any questions, complete the following:
(a) routinely (e.g. 11am every day)	<input type="checkbox"/> No <input type="checkbox"/> Yes⇒	Administer at __: __ am/pm on the following days: (circle the day/s required) Monday Tuesday Wednesday Thursday Friday
(b) for a short time only (e.g. only for 2 weeks)	<input type="checkbox"/> No <input type="checkbox"/> Yes⇒	Start date: __/__/____ End date: __/__/____
(c) to manage a health condition by following a current action plan or health plan	<input type="checkbox"/> No <input type="checkbox"/> Yes⇒	Is the medication for: <input type="checkbox"/> asthma <input type="checkbox"/> anaphylaxis <input type="checkbox"/> diabetes <input type="checkbox"/> epilepsy <input type="checkbox"/> cystic fibrosis <input type="checkbox"/> other (describe)
(d) 'as needed' to treat minor or non-emergency symptoms	<input type="checkbox"/> No <input type="checkbox"/> Yes⇒	<input type="checkbox"/> I understand that before UQSL administers this medication, if they are not aware of when this medication was most recently given to this child, I will be contacted to provide this information.

Has this child previously shown any side effects after taking this medication? Yes No

If Yes, describe: _____

Parent/carer/student signature		Date	
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If the child is to self-administer this medication, also complete **Section B**

NOTE: Controlled drugs cannot be self-administered.

Section B: Details for child self-administration of medication:

In all cases and at any time, UQSL may disallow child self-administration for health and/or safety reasons.

Student name		Date of birth	
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- I confirm that the child is confident, competent and can safely administer the right dose of their own medication at the right times.
- I confirm that the child can store their medication securely.
- I authorise UQSL staff to contact the prescribing health practitioner, health team or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication by this child.

Health condition	
<input type="checkbox"/> Asthma - secondary school students only	<input type="checkbox"/> I approve for my child to self-administer their asthma medication. NOTE: UQSL will need a copy of the child's <i>Asthma Action Plan</i> if it varies from the standard asthma first aid response

Health condition	I seek approval from UQSL for my child to self-administer:
<input type="checkbox"/> Asthma	<input type="checkbox"/> their asthma medication (<i>following a current action plan/health plan</i>)
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> their adrenaline auto-injector (<i>following a current action plan/health plan</i>)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> their medication (<i>following a current health plan</i>)
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> their medication (<i>following a current health plan</i>)
<input type="checkbox"/> Other _____	<input type="checkbox"/> their medication (<i>following a current health plan</i>)

Parent/carer signature		Date	
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