REQUEST TO ADMINISTER MEDICATION AT SCHOOL

Note: If your child is to take more than one prescribed medication, ***please attach a separate request for each medication.***

SCHOOL NAME and ADDRESS: .....

STUDENT NAME: .....**Gender:** .....

DATE OF BIRTH / / **YEAR LEVEL:** .....

To be completed by Parent / Guardian with the Prescribing Health Practitioner and returned to the SCHOOL.

Please identify the medication ***(prescribed or 'over the counter')*** *that the student requires during school hours including any emergency medication.*

Name of prescribed medication: .....

Dosage (e.g. 5 mg) **and Route of administration** (e.g. oral, by injection)
.....

Time to be given: .....

Special instructions for administering the prescribed or 'over the counter' medication (e.g. must be taken with food or with a glass of water).....

.....

Prescribed for (name of medical condition): .....

.....

Special medication storage instructions (if any e.g. store in refrigerator): .....

.....

Are there any likely side effects from this medication? No ☐ Yes ☐

Describe the side effects: .....

If your child administers his or her own medication at home, do you request that he or she self -administers this medication at school? No ☐ Yes ☐

Please describe what support your child needs to administer the medication in a non - emergency situation at school. You may like to include information about how you support your child at home to administer their medication. .....

.....

Note: *the Principal needs to approve a decision for a student to self -administer.*

REQUEST TO ADMINISTER MEDICATION AT SCHOOL

I request that school staff administer the necessary medication to this student,

Name: ..... **DOB**: .....

while at school. I confirm the above information provides the school with the complete and necessary information to administer the medication. I also understand and agree that it is my responsibility (parent / guardian) to provide the school with the prescribed or 'over the counter' medication and inform the Principal of any changes involving the administration of the medication and will do so in writing as specified in the 'Administration of Medication in Schools Policy' and Guidelines for Administering Medications in Schools' for Diocesan Systemic Schools.

Parent / Guardian – PRINT NAME: .....

Address: .....

Home phone: ..... Work phone: .....

Mobile phone: ..... Email: .....

Signature: .....**Phone:** .....**Date**: .....

Prescribing Health Practitioner – PRINT NAME.....

Practice address: .....

Phone: ..... Email :.....

Qualifications: .....

Apply practice stamp here:

Signature: .....**Phone**: .....**Date**: .....

This authorisation applies for the period Term to Term Year: .....

NOTE: For **school staff** to administer any medication including '*over the counter medication'*, **authorisation is required from a Prescribing Health Practitioner.**

Privacy notice: The information requested on this form is essential for assisting the school to plan for the support of your child's health needs. It will be used by the school for the development of arrangements with you to support your child's health needs. Provision of this information is voluntary. If you do not provide all or any of this information, the school's capacity to support your child's health needs could be impaired. This information will be stored securely. You may correct any personal information provided at any time by contacting the Principal.

Office Only: *When this course of medication concludes, please retain this form in the student's school file.*