REQUEST TO ADMINISTER MEDICATION AT SCHOOL

N.B If your child is to take more than one prescribed medication, ***please Attach a separate request for each medication.***

Insert Student Photo

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 5mg) **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 likely to be any side effects for this medication? NO ☐ YES ☐

Describe the side effects:……..

If your child administers their own medication at home, do you request that they self-administer at school? N/A ☐ 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 must approve a decision for a student to self-administer.*

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.

Parent /Guardian- PRINT
NAME:……

Address:……

Home Phone:……..Work Phone:……

Mobile Phone:…….Email:……

Signature:…….Date:……

Prescribing Health Practitioner- PRINT
NAME:…….

Practice address:……..

Phone:……Email:……

Qualifications:……

APPLY PRACTICE STAMP HERE

Signature:……..**Date:**…….

This authorisation applies for the period (insert dates) / / to / /

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 arrangement 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 via the school office.

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