MACKILLOP Catholic College WARNERVALE

Request to Administer Medication in 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 the Prescribing Health Practitioner with the Parent / Carer and return 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: ____

____

Parent / Carer to complete:

If your child administers his or her own medication at home, do you request that he or she self-administers this medication 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 needs to approve a decision for a student to self-administer.

Last Revised: 1 December 2017

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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 / carer) 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 'Medication Policy' for Diocesan Systemic Schools.

Parent / Carer – PRINT NAME: ____

Address: ____

Home phone: _________________________ Work Phone: _________________________

Mobile phone: _________________________ Email: ____

Parent signature: _________________________ Phone: ____________________ Date: ___________

Prescribing Health Practitioner – PRINT NAME: ____

Practice address: ____

Phone: Email: ____

Qualifications: ____

Apply practice stamp here:

Prescribing Health Practitioner 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.
This form will not be accepted by school staff unless it has been completed, signed and stamped by the 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 of 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.*