

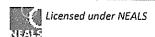
REQUEST TO ADMINISTER MEDICATION IN SCHOOL

| I request that school staff adm | ninister the necessary medication to this | student, |
|---|--|---|
| Name: | DOB: | |
| necessary information to admiresponsibility (parent / carer) temporal medication and inform the Prires. | above information provides the school wit inister the medication. I also understand to provide the school with the prescribed ncipal of any changes involving the administration as specified in the 'Medication Policy in the 'Me | and agree that it is my or 'over the counter' nistration of the |
| Parent / Carer – PRINT NAM | E: | ••••••••••••••••••••••••••••••••••••••• |
| Address: | | |
| Home phone: | Work phone: | |
| Mobile phone: | Email: | |
| Parent Signature: | Phone: | Date: |
| Prescribing Health Practitio | ner – PRINT NAME: | |
| Practice address: | | |
| Phone: | Email : | |
| Qualifications: | •••••• | |
| Apply practice stamp here: | | |
| Prescribing Health Practitio | ner Signature: | |
| Phone:Date: | · | |
| This authorisation applies fo | or the period Term to Term | Year: |
| | ninister any medication including 'over the a Prescribing Health Practitioner. | e counter medication', |

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 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.





APPENDIX 4



REQUEST TO ADMINISTER MEDICATION IN SCHOOL

Insert student photo

| 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 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: |
| 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. |

Continue to Page 2....