CATHOLIC SCHOOLS Broken Bay

Insert student photo

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			
SCHOOL ADDRESS			
STUDENT NAME:			
DOB:	GENDER:	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):		**Time to be given:**	
Route of administration (e.g. oral, by injection)			
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		
If "Yes" describe the side effects			
I hereby authorise medications specified on this form to be administered according to these instructions			
Prescribing Health Practitioner **PRINT NAME:**		**Signature:**	
Practice Address:			
Telephone:		**Email:**	
Qualifications:		**Date:**	

Apply practice stamp here:			
This authorisation applies for the period:	**Term:** **to Term:**	**Year:**	

To be completed by Parent/Carer

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

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 Catholic Schools *'Medication Policy'.*

Parent/Carer PRINT NAME:

Address:			
Home Phone:		**Work Phone**	
Mobile Phone:		**Email:**	
Parent Signature:		**Date:**	

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

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.*

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 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.*