St. Paul's Catholic Parish Primary School
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REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

1. Student Details

First name: _____Surname: _____

Date of Birth: _____School: St Paul's Catholic Primary, Moss Vale Class: _____

2. Health / Medical Condition

Please complete a separate request for each health/medical condition requiring medication.

Medical Condition: _____

Details:_____

_____

_____

Could your child experience an emergency reaction in relation to this condition? Yes □ No □

If yes, please provide details of reaction:

_____

_____

Has medication been *prescribed* by a medical practitioner for this condition?

Yes □ **(please complete Section 3)** No □

Is Over-The-Counter medication required for this condition? Yes □ **(please complete Section 3)** No □

OVER-THE-COUNTER MEDICATION

NOTE: Over-The-Counter medication will *NOT* be administered by school staff unless the below has been stamped and signed by a Medical Practitioner/Pharmacist.

Apply practice stamp here:

Medical Practitioner Signature: _____

3. Medication Instructions

Name of medication: _____ Dosage: _____

Time required to be administered: _____

Commencement date: _____Conclusion date:_____

Medication must be provided in the original packaging with student name and dosage as well as a weekly pill box for dispensing purposes.

Expiry date of the medication: _____

Special storage requirements if any (e.g. in refrigerator):

_____

Special instructions for administering the medication e.g. must be taken with food:

_____

Are you aware of any likely side effects from the medication? Yes □ No □

If yes, please provide details of side effects:

_____

_____

4. Medical Practitioners Contact Details

In an emergency requiring medical attention, I authorise the school to contact:

Medical Practitioner's name/medical centre: _____

Address: _____Phone number: _____

5. Carry / Self-Administer Medication Request

For some medications and some students, it can be appropriate for the student to self-administer their medication without any adult supervision, and carry their own medication to and at school eg Asthma.

Would you like the school to consider a request for your child to carry and self-administer their own medication **(Yr 3 - 6 only)?** Yes □ No □

If yes, please provide details of what medication your child will carry, and where your child will store their medication (e.g. in a medical pouch)?

_____

_____

I consent to my child carrying the left over medication home - Yes □

If no, parents need to come to the office to collect it.

***Principal or their delegate will assess any associated risks at the school level before approving a student to self-administer and carry their own medication.**

****Schedule 8 drugs (e.g. Ritalin) must be kept in the administration office due to the safety risk posed to other students.**

6. Parent / Carer Contact Details

Name:_____

Relationship to child: _____

Address: _____

Home phone: _____ Work phone: _____

Mobile phone: _____ Email: _____

Parent / Carer consent signature: _____Date: _____