STUDENT MEDICATION REQUEST

Note:
Where possible student medication should be self-administered by the student or be administered by parents at home at times other than school hours. If the Principal of the school is to approve staff administering or supervising the administration of medication to a student, then the following requirements must be met.

The doctor prescribing the drug must be aware that the school will supervise or carry out administration of the medication on the instructions provided within the constraints of other duties and without medical knowledge. It is therefore necessary that the doctor provide instructions – as per “Medical Instructions from Prescribing Doctor”. These instructions are a mandatory requirement and are necessary when the school staff agree to administer the drug, supervise the administration of the drug, or monitor the student after drug administration.

Drugs for administration should be delivered to the school office by a parent or care giver into the care of a staff member. The school will prepare a student medication record and store the drugs in a secure place. All drugs should be contained in properly labelled containers showing the name of the drug, the name of the student and the appropriate dose and frequency and the expiry date of the medication.

PLEASE PRINT
Name of parent/guardian/carer __________________________________________________
Name of student _____________________________________________________________
Year & Class ________________________________________________________________
Name of prescribing doctor _____________________________________________________
Medical condition being treated _________________________________________________

Name of drug ________________________________________________________________ Dose________
Time to be taken _____________________________________________________________
(It is the responsibility of the parent/guardian/carer to provide the correct drug properly labelled. Improperly labelled drugs will not be administered)
Commencement date ________________ Conclusion Date ________________________
Replacement date of drug if appropriate ___________________________________________
Comments (any additional information may be attached)

Note: 1 A new request/record agreement need to be made:
- If the dose or medication type is altered
- If the regime is re started following the expiration of this order
- At the beginning of each NEW calendar year
- If the designated teacher alters

Note: 2 This agreement form is only valid in conjunction with Medication Instructions from Prescribing Doctor.
- I ________________________ confirm that if this medication is not administered my child’s life will not be at risk.
- In requesting the staff member to administer this medication I am aware/accept that the responsibility is mine if in the course of the school day these instructions are not followed.
- I confirm that to the best of my knowledge my child is not allergic to this medication.
- I confirm my child is fit enough to attend school.

Parents signature ________________________ Date ___________

MEDICATION INSTRUCTION FROM PRESCRIBING DOCTOR
These instructions are requested from the prescribing doctor to enable the school to maintain its ‘duty of care’ when administering prescribed drugs to students whose condition would otherwise preclude attendance at school.

Dr ________________________________________ Phone __________________________
Address ____________________________________________________________________
I have prescribed the drug _____________________________________________________
For (name of student) ___________________________________ Date of Birth ___________
To treat the medical condition __________________________________________________
This drug need to be administered (dose) _____________ (frequency/time) _______________
Are special arrangements necessary to administer the drug or monitor the student after drug administration? YES ___ (Please provide details below) NO ____

Details of Special Arrangements

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Signature of Prescribing Doctor __________________________  Date __________________

Note: The information collected on this form will be treated in accordance with the principles described in Liwara Catholic School’s Privacy Policy