LIWARA
Catholic Primary School

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 self 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 _____
Number of tablets/mls given to school: _____
(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.