Dear Parent/Guardian

Re: Administration of Medication

Please find attached the forms that need to be completed so that medication can be administered to your child during the school day.

These forms have been designed to ensure the safety of your child and to protect the school staff who do not have medical training.

Form 1 is to be completed by you. Form 2 is to be completed by the medical practitioner prescribing the medication. Once completed, please return all forms to the school.

I am aware that this may seem a complicated process but please be assured that the school will give you every assistance with this matter.

Please do not hesitate to contact me if I can be of further assistance to you.

Yours sincerely

Fran Jackson

Mrs Fran Jackson
Principal
NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE
ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To be completed by parent or guardian

I request that my child __________________________ be allowed to take medication
(full name of student)

at school according to instructions from _______________________________________.
(full name of prescribing doctor)

Address of prescribing doctor: ________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Contact number: ____________________________________________________________

The medication has been prescribed for the following reason:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

I hereby give permission to the Principal to obtain relevant information from the prescribing doctor. I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medicine.

Signed: _______________________________ Date: ______________

(full name of student) (full name of prescribing doctor)
MEDICAL ADVICE TO SCHOOL

To be completed by prescribing doctor

Student's full name: _____________________________________________________________

1. Medical condition(s) of the child requiring regular treatment:
____________________________________________________________________________
____________________________________________________________________________

2. Essential medication requiring administration during school hours:

Medication Details

<table>
<thead>
<tr>
<th>Condition name</th>
<th>Medication name</th>
<th>Dosage</th>
<th>Time/s of administration</th>
<th>Special instructions</th>
<th>Self-administration (yes/no)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

3. Recommended restrictions on participation in school activities (e.g. sport, use of tools or machinery):
____________________________________________________________________________
____________________________________________________________________________

4. Recommended procedure in crisis situation
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

5. Additional comments:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Signature of prescribing doctor: ___________________________  Date: __________

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