St Joseph's Primary School – Kingswood

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.

Form1 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

St Joseph's Primary School 94 Joseph Street Kingswood 2747
Tel 4732 3999 Fax 4721 3349
Email stjosephskwood@parra.catholic.edu.au wwwstjosephskingswood.parra.catholic.edu.au

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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:_____

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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

Condition name	Medication name	Dosage	Time/s of administration	Special instructions	Self-administration (yes/no)

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:_____

Learning without limits

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