Medical Action Plan 2015

Dear ________________

Please find attached 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.

Please make sure the enclosed forms are completed by the treating Doctor and that the Doctor signs & stamps the form. Also attach a current photo of your child where indicated.

Once the forms have been completed please return them to the school office.

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

Yours sincerely

K Williams

Kevin Williams
Principal
29th January 2015

Vision/Mission Statement

"Empowered by the Spirit, we at St Mary’s live, learn and grow as disciples of Jesus in a nurturing Catholic Community."
REQUEST TO ADMINISTER MEDICATION AT SCHOOL

Note: If your child is to take more than one prescribed medication, please attach a separate request for each medication.

SCHOOL NAME and ADDRESS: ........................................................................................................

STUDENT NAME: .........................................................................................................................Gender: ................................

DATE OF BIRTH / / YEAR LEVEL: ................................................................................................

To be completed by Parent/Guardian with the Prescribing Health Practitioner and returned to the SCHOOL.

Please identify the medication (prescribed or ‘over the counter’) that the student requires during school hours including any emergency medication.

Name of prescribed medication: ...................................................................................................

Dosage (e.g. 5 mg) and Route of administration (e.g. oral, by injection)

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Time to be given: ..............................................................................................................................

Special instructions for administering the prescribed or ‘over the counter’ medication
(e.g. must be taken with food or with a glass of water).................................................................

...........................................................................................................................................................

Prescribed for (name of medical condition): ..................................................................................

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Special medication storage instructions (if any e.g. store in refrigerator): .................................

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Are there any likely side effects from this medication? No ☐ Yes ☐

Describe the side effects: ..................................................................................................................

...........................................................................................................................................................

If your child administers his or her own medication at home, do you request that he or she
self-administers this medication at school? N/A ☐ No ☐ Yes ☐

Please describe what support your child needs to administer the medication in a non-
emergency situation at school. You may like to include information about how you support
your child at home to administer their medication. ..............................................................................

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Note: the Principal needs to approve a decision for a student to self-administer.
REQUEST TO ADMINISTER MEDICATION AT SCHOOL

I request that school staff administer the necessary medication to this student.

Name: ___________________________ DOB: ______________________

while at school. I confirm the above information provides the school with the complete and necessary information to administer the medication. I also understand and agree that it is my responsibility (parent / guardian) to provide the school with the prescribed or ‘over the counter’ medication and inform the Principal of any changes involving the administration of the medication and will do so in writing as specified in the ‘Administration of Medication in Schools Policy’ and Guidelines for Administering Medications in Schools’ for Diocesan Systemic Schools.

Parent / Guardian – PRINT NAME: __________________________________________

Address: ........................................................................................................

Home phone: __________________ Work phone: _____________________________

Mobile phone: __________________ Email: _________________________________

Signature: ______________________ Phone: __________________ Date: __________

Prescribing Health Practitioner – PRINT NAME: ___________________________

Practice address: _______________________________________________________

Phone: __________________ Email: __________________________________________

Qualifications: __________________________________________________________

Apply practice stamp here:

Signature: ______________________ Phone: __________________ Date: __________

This authorisation applies for the period Term ______ to Term ______ Year: _________

NOTE: For school staff to administer any medication including ‘over the counter medication’, authorisation is required from a Prescribing Health Practitioner.

Privacy notice: The information requested on this form is essential for assisting the school to plan for the support of your child’s health needs. It will be used by the school for the development of arrangements with you to support your child’s health needs. Provision of this information is voluntary. If you do not provide all or any of this information, the school’s capacity to support your child’s health needs could be impaired. This information will be stored securely. You may correct any personal information provided at any time by contacting the Principal.

Office Only: When this course of medication concludes, please retain this form in the student’s school file.