# St Mary's Catholic Primary School, Toukley

**Address:** 458 Main Road, Noraville NSW 2263
**Telephone:** (02) 4396 5100
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**Email:** smt@dbb.catholic.edu.au
**Website:** www.smtdbb.catholic.edu.au


**ADMINISTRATION OF MEDICATIONS IN SCHOOLS**

The Broken Bay Diocesan Schools System 'Medication policy' and 'Administration of Medication in Schools: Guidelines and Procedures' have been revised.

*St Mary's Toukley* is committed to supporting students' health and wellbeing. We require parents / carers providing the school with any relevant health information that is required to support the student at school. While this information is collected at enrolment it needs to be updated regularly, including when a new health condition develops. Information about medically diagnosed conditions such as allergies, asthma, diabetes, epilepsy and other health conditions that may require school staff to provide support to students; ***(including the administration of medication – prescription or over the counter medication and the need to perform health procedures)***: will need to be provided to the school in writing in the form of an ***'action plan'*** **or** ***'health care management plan'*** and signed by both the parent / carer and a medical practitioner or a prescribing health practitioner. This must then be discussed with the school. Additionally, any student health care need, action plan or health care management plan that may impact on school activities such as sports, excursions (including camps) must be provided in writing and supported by a medical practitioner / prescribing or qualified health practitioner's advice.

**All Broken Bay systemic schools require medical authorisation from a prescribing medical or health practitioner to administer any medication to students (including over the counter medications such as Paracetamol, Claratyne etc).**

Please ensure you inform the school office staff of any changes to contact details including the contact details of the people nominated as emergency contacts.

We thank you for your assistance in this matter.

All information is kept confidential and only disclosed to the relevant staff who are supporting your child.

For any enquiries, please contact the school office on telephone the school on *4396 5100.*

**APPENDIX 4**

# REQUEST TO ADMINISTER MEDICATION IN SCHOOL

Insert student photo

***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 the Prescribing Health Practitioner with the Parent / Carer 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)

……..

**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): …….

……..

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

……..

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

Describe the side effects: ……

***Parent / Carer to complete***

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. ……..

……

***Note:*** *the Principal needs to approve a decision for a student to self -administer.*

***Continue to Page 2….***

# REQUEST TO ADMINISTER MEDICATION IN 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 / carer) 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 *'Medication Policy'* for Diocesan Systemic Schools.

**Parent / Carer – PRINT NAME**: ……..……..

Address: …….

Home phone: …… Work phone: ……

Mobile phone: …… Email: ……..

Parent Signature**:** ……**Phone:** ……**.Date**: ……..……..

**Prescribing Health Practitioner – PRINT NAME:** ……..

Practice address: ……..

Phone: …… Email :…….

**Qualifications:** ……..

**Apply practice stamp here**:

**Prescribing Health Practitioner 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.**
***This form will not be accepted by school staff unless it has been completed, signed and stamped by the 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.*