Kandos HIGH SCHOOL

REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION TO STUDENT

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

STUDENTS NAME:_____ **D.O.B:**_____

NAME OF PRESCRIBED MEDICATION:_____

PRESCRIBED FOR (NAME OF MEDICAL CONDITION):_____

PRESCRIBED DOSAGE:_____
(Please indicate time of dosage)

Name, address and phone number of Doctor in regards to this condition:_____

_____

What are you requesting the school to do?

_____

_____

Expiry date of the medication**:** _____
*(**Note**: if you can't provide this information now we will need to know the expiry date when the medication is given to the school.)*

Special storage requirements if any, eg. In refrigerator**:** _____

Special instructions for administering the prescribed medication/s, eg. Must be taken with food or with glass of water: _____

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

☐ Yes ☐ No If Yes, Please provide more information:

_____

_____

If your child administers his or her medication at home, do you request that he or she self-administers this medication at school?

☐ Yes ☐ No

Note: The Principal needs to approve a decision for a student to self-administer. Under School guidelines and Department Policy certain medication will not be allowed to be self-administered.

If your child self-administers the medication at home, what level of support do you provide? (Please describe) _____

_____

Name of person who will carry the medication school:_____

REQUEST FOR OTHER SUPPORT

_____

_____

_____

_____

Parent Name _____ Contact Number: _____

Parent Signature _____ Date _____

Principal's Signature_____ Date _____

Non Prescription Medication – Department of Education guidelines do not permit the school to administer "over the counter" medication unless, as with prescribed medication, its use for a particular student has been authorised by a doctor. If it is necessary for your child to take non-prescription medication at school please request that your doctor sign below and indicate on page 1 the relevant dosage and name of the medication in addition to an **asthma action plan** if required.

Doctor's Name/Medical Centre _____

Doctor's Address _____

Doctor's Signature_____ Date _____

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 NSW Department of Education and Training 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 personal information provided at any time by contacting the Principal.