St Patrick’s Primary, Gympie
Student Medication Request Form
2016

This form must be completed for medication to be administered to your child during school hours. It has been designed to ensure the safety of your child and to protect school staff who do not have medical training.

This form can be signed by either the medical practitioner or the parent/guardian.
Please return the completed form to the school.

Where possible, medication should be administered to your child at home at times other than during school hours. Furthermore, for the Principal to undertake to assist in administering medication to your child, the following requirements must be met:
1. You must provide the information required in Section 1 below;
2. All medication supplied to the school for your child must be in a container labelled by a pharmacist, showing the name of the drug, the “use by” date, the name of the student’s medical practitioner, the name of the student, the dosage and the frequency of administration.

**Section 1**
MEDICATION INSTRUCTIONS

These instructions are requested from the student’s medical practitioner or parent/guardian to enable the school to maintain its duty of care when administering medication to students whose condition would otherwise preclude attendance at school.

Medical Practitioner’s name: ________________________
Address: _____________________________________________ Phone: ______________________

Name of student: ______________________________________
Name of Medication: __________________________________
Dose: __________________________________ Time to be taken: ______________________
Commencement date: __________________ Conclusion date: __________________

Special arrangements: (eg. monitoring the student after administration; restrictions on participation in school activities such as sports or use of machinery; side effects; emergency actions.)

____________________________________________________

Signed: ______________________ Date: ________________
(Student’s Medical Practitioner or Parent/Guardian)

**Section 2**
NOTIFICATION AND REQUEST BY PARENT/PERSON WITH LEGAL RESPONSIBILITY FOR STUDENT FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

I request administration of medication as instructed above for my son/daughter.

Full name of student: ______________________ Date of Birth: ________ Grade: ______

**Note 1:** A new Student Medication Request Form must be completed:
- If the dose or type of medication is altered;
- If the regime is re-started following the conclusion date of the instructions from the medical practitioner above;
- At the beginning of each new calendar year;

**Note 2:** This Form is only valid when instructions for the administration of medication have been provided above.

Signed: ______________________ Date: ________________
(Parent or person with legal responsibility for the student)

https://portals.bne.catholic.edu.au/schools/stpatrickspsgympie/staff/Administration Drive/General Admin/WHandS/Medication/Student Medication Request Form 2016.doc