



# St Patrick's Primary, Gympie

## Student Medication Request Form

2020

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 & 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)*