ALBURY PUBLIC SCHOOL

481 David Street
ALBURY 2640
Tel: 6021 3849
Fax: 6041 1265

REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION TO STUDENTS

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

NAME OF STUDENT:………………………………………………… **Class**………….

NAME of **PRESCRIBED MEDICATION**:…………………………………………………

PRESCRIBED for (Name of **MEDICAL CONDITION**)……………………………………

PRESCRIBED **DOSAGE**:……………………………………………………………………

What are you requesting the school to do?...
………………………………………………………………………………………………
………………………………………………………………………………………………

SPECIAL STORAGE requirements if any eg *in refrigerator*:……………………………

Special instruction for administering the prescribed medication/s eg *must be taken with food or with a glass or 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 own 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).

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 to school …………………………………
………………………………………………………………………………………………

REQUEST FOR OTHER SUPPORT

………………………………………………………………………………………………..

……………………………………………………………………………………………..

……………………………………………………………………………………………..

Parent or carer signature:……………………………………………..Date:………………………

Privacy notice

The information requested on the 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 any personal information provided at any time by contacting the Principal.

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REQUEST FOR SUPPORT AT SCHOOL OF A STUDENT'S HEALTH CONDITION

INFORMATION

NAME OF CHILD……………………………………………CLASS ……………….

Date of Birth…………………………

☐ Enrolled or ☐ Seeking enrolment (tick)

CLASS (if enrolled)…………………………

PARENT CONTACT

Name:……………………………………………………………………………..
Relationship to child:………………………………………………………………..
Address:…………………………………………………………………………….
Home Phone:……………………………… Work Phone:……………………
Mobile Phone……………………………………………………………………..

Medical Practitioner Contact

Name:…………………………………………Phone……………………………..

HEALTH / MEDICAL CONDITION

……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………

Could your child experience an emergency reaction in relation to this condition?

☐ Yes ☐ No

PROCEDURES IN CASE OF EMERGENCY:-

……………………………………………………………………………………..
……………………………………………………………………………………..
……………………………………………………………………………………..
………………………………………………………………………………………
………………………………………………………………………………………

I give permission for these procedures to occur if necessary.

SIGNED:……………………………………………
DATE:……………………………