REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION TO THE STUDENT

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

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 instructions for administering the prescribed medication (eg must be taken with food or with 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)

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

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Signed: ___________________________________________ Date: _______________________________

Parent/Guardian

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.