St Justin's Catholic Primary School
Oran Park

PO Box 889, Narellan 2567
94 Oran Park Drive, ORAN PARK NSW 2570
Phone – 4651 3800 Fax – 4651 3805

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

1. Student Details

First name: _____Surname: _____
Date of Birth: _____School:_____ Class: _____

2. Health / Medical Condition

Please complete a separate request for each health/medical condition requiring medication.

Medical Condition: _____
Details:_____
_____
_____

Could your child experience an emergency reaction in relation to this condition? Yes ☐ No ☐

If yes, please provide details of reaction:

_____
_____
_____

Has medication been *prescribed* by a medical practitioner for this condition?

Yes ☐ **(please complete Section 3)** No ☐

Is Over-The-Counter medication required for this condition? Yes ☐ **(please complete Section 3)** No ☐

OVER-THE-COUNTER MEDICATION

NOTE: Over-The-Counter medication will not be administered by school staff unless the below has been stamped and signed by a Medical Practitioner.

Apply practice stamp here:

Medical Practitioner Signature: _____

3. Medication Instructions

Name of medication: _____ Dosage: _____

Time required to be administered: _____

Commencement date: _____Conclusion date:_____

Expiry date of the medication: _____

Special storage requirements if any (e.g. in refrigerator):

_____

Special instructions for administering the medication e.g. must be taken with food:

_____

Are you aware of any likely side effects from the medication? Yes ☐ No ☐

If yes, please provide details of side effects:

_____

_____

4. Medical Practitioners Contact Details

In an emergency requiring medical attention, I authorise the school to contact:

Medical Practitioner's name/medical centre: _____

Address: _____Phone number: _____

5. Carry / Self-Administer Medication Request

For some medications and some students, it can be appropriate for the student to self-administer their medication without any adult supervision, and carry their own medication to and at school.

Would you like the school to consider a request for your child to carry and self-administer their own medication?

Yes ☐ No ☐

If yes, please provide details of what medication your child will carry, and where your child will store their medication (e.g. in a medical pouch)?

_____

_____

***Principal or their delegate will assess any associated risks at the school level before approving a student to self-administer and carry their own medication.**

****Schedule 8 drugs - Medication that requires a prescription and has a higher potential for misuse, abuse and dependence. Examples include Ritalin, anti-depressants. Schedule 8 drugs must be kept in the administration office due to the safety risk posed to other students.**

6. Parent / Carer Contact Details

Name:_____

Relationship to child: _____

Address: _____

Home phone: _____ Work phone: _____

Mobile phone: _____ Email: _____

Parent / Carer consent signature: _____Date: _____