LUGARNO
Public School

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Request for children requiring administration of prescribed medication at school

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

Please complete this form on the basis of information provided by your medical practitioner and/or pharmacist and return it to the school. The school will then contact you again to confirm arrangements.

Please advise the school principal at any time if there are changes in the information about your child's health care needs.

Name of student: _____

Roll Class: _____ Scholastic Year: _____

Medicare No: _____ Position No: _____ Exp Date: _____

Name of prescribed medication:

_____

Prescribed for (name of medical condition):

_____

Prescribed dosage:

_____

What are you requesting the school to do?

_____

_____

Medication

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

_____

Special instructions for administering the prescribed medication/s e.g. must be taken with food or with a glass of water:

_____

Through information you have 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? (Note: The Principal needs to approve a decision for a student to self-administer).

Yes ☐ No ☐

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: _____

Medical Practitioner Name: _____

Address: _____

Phone: _____ Fax: _____

Parent Contact Details

Parent/Caregiver Name: _____

Relationship to child: _____

Parent/caregiver signature: _____ Date: ____/____/_____

Best contact number: _____

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 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.

Principal Approved ☐ Yes ☐ No

Name of Principal: Justine Williams

Signature of Principal: _____ Date: ____/____/_____