SCHOOL NAME: _____

Catholic Education
Diocese of Rockhampton

REQUEST TO ADMINISTER MEDICATION AT SCHOOL

Name of Student: _____ **Date of Birth:** _____

Important Information

For school staff to administer over-the-counter medication, authorisation is required from a medical practitioner. An original pharmacy label with the child's name, dosage and time to be taken can be accepted as authorisation.

Please list all medications your child requires during school hours or emergency medications they may require.

Name of Medication	Dosage	Time to be Administered	Dates to be Administered	Other Instructions or Information

Please Note:

The following points are for security and safety purposes, and are requirements of the *Health (Drug and Poisons) Regulation 1996 (Qld)*.

- The parent notifies the school in writing to administer medication. This may include written guidelines from the prescribing health practitioner, including potential side effects or adverse reactions.
- Provide medication in **original pharmacy labelled container** to the school.
- Ensure medication is not out of date and has an original pharmacy label with the student's name, dosage and time/s to be taken.
- Notify the school in writing when a change of dosage is required. This instruction is to be accompanied by a letter from a prescribing health practitioner or change of label from a pharmacist.
- The student has received a dose at home without ill effect.
- Advise the school in writing and collect the medication when it is no longer required at school.
- Where parents are working with a prescribing health practitioner to determine a dose for that day (e.g. insulin, Rivotril) parents will provide a letter from the prescribing health practitioner instructing that parents will be responsible for notifying the school of the adjusted dose.
- This form will be reviewed annually or as the students is prescribed a change in medication.

I hereby request that school staff administer the necessary medication to my child while at school.

I agree to notify the school, in writing, if there are any changes in the above medication.

Parent's Name: _____ ***Signature:*** _____ ***Date:*** _____

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ADMINISTRATION OF MEDICATION RECORD

Name of Student: _____ **Date of Birth:** _____

(Confirm name of student verbally and on medication before administering).

Medication: _____

Date	Time	Administered by	Signature