WHITTALL ST, RUSSELL LEA NSW 2046
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REQUEST FOR CHILDREN REQUIRING ADMINISTRATION OF PRESCRIBED MEDICATION AT SCHOOL

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

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

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

STUDENT DETAILS	
STUDENTS NAME	
ROLL CLASS	
SCHOLASTIC YEAR	
MEDICATION DETAIILS	
NAME OF PRESCRIBED MEDICATION	
PRESCRIBED FOR *(NAME OF MEDICAL CONDITION)*	
PRESCRIBED DOSAGE	
WHAT ARE YOU REQUESTING THE SCHOOL TO DO?	
MEDICATION STORAGE *EG. IN THE FRIDGE*	

SPECIAL INSTRUCTIONS FOR ADMINISTERING MEDICATION *EG. TAKEN WITH FOOD*	
THROUGH INFORMATION YOU HAVE FROM YOUR DOCTOR OR AQUIRED YOURSELF, ARE YOU AWARE OF ANY LIKELY SIDE EFFECTS?	☐ NO ☐ YES. PLEASE PROVIDE MORE INFORMATION
IF YOUR CHILD SELF ADMINISTERS HIS/HER OWN MEDICATION AT HOME, DO YOU REQUEST THAT HE/SHE SELF ADMINISTERS AT SCHOOL? (*NOTE: THE PRINCIPAL MAY NEED TO APPROVE A DECISION FOR A STUDENT TO SELF ADMINISTER*)	☐ NO ☐ YES. IF YOUR CHILD SELF ADMINISTERS PLEASE DESCRIBE WHAT LEVEL OF SUPPORT YOU PROVIDE.
NAME OF PERSON WHO WILL CARRY THE MEDICATION TO SCHOOL	
MEDICAL PRACTITIONER DETAILS	
MEDICAL PRACTIONER NAME	
MEDICAL PRACTIONER PHONE NO.	
MEDICAL PRACTITIONER ADDRESS	
PARENT DETAILS	
PARENT NAME	
PARENT SIGNATURE	
DATE	