St Angela's Primary School

40 Harrington Ave Castle Hill NSW 2154
Ph: (02) 9894 9377
Fax: (02) 9894 9159

(School Form 2017MED-DRFORM) During School Hours
Doctor's Form For Administration and Storage of PRESCRIBED Medication
TO BE COMPLETED BY DOCTOR AND PARENT

Parent Name: _____

Child's Name: _____

Child's Class: _____

Dear Parents,

RE: ADMINISTRATION AND STORAGE OF PRESCRIBED MEDICATION

My child requires prescribed medication to be permanently stored at school, in order to be administered during the school day, for the following condition/s:

- □ Anaphylaxis
- □ Allergies
- □ Asthma
- □ Other (please specify)

Please complete and return the attached Forms 1 and 2 as detailed below:

- **Form 1:** To be completed by **YOU**
- **Form 2:** To be completed by **YOUR CHILD'S PRESCRIBING DOCTOR**

If your child suffers from anaphylaxis or allergies, an updated action plan **must** accompany these forms. For your convenience, both anaphylaxis and allergy action plans are attached or can be downloaded from www.allergy.org.au. The relevant action plan for your child's condition is required to be completed by your **child's doctor** with a **current photograph of your child**. Once completed, please return action plan together with Forms 1 & 2 to the school office. As you can appreciate, it is imperative that our records remain current. These forms comply with the procedure recommended by the Catholic Education Office and have been designed to ensure the safety of your child.

When supplying the school with medication for your child, please note and diarise the expiry date of the medication. It is the responsibility of **parents** to ensure that their child's medication remains current.

If at any time there is a change to your child's medication requirements, or no longer require medication to be stored at school, please notify the school office by email at stangelas@parra.catholic.edu.au.
Please note: If your child requires prescription medication to be administered on a short term basis only (1-5 days) eg. seasonal asthma, antibiotics and does not require permanent storage of medication at school, you are not required to have forms completed by your child's doctor. When required, please complete the Short Term Basis Form (School Form 2017 MED-STB) on our website, which requires parent authorisation only.

We thank you for your support in this important matter and please do not hesitate to contact the office for further assistance.

Yours sincerely,

Tony Calabria
Principal

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FORM 1
TO BE COMPLETED BY PARENT/GUARDIAN
and returned to School Office

Notification and Request by Parent/Guardian for the Administration of Prescribed Medication during School Hours

I request that my child, _____ be administered medication at school
(Child's Name)
according to instructions from:

_____
Full Name of Prescribing Doctor

_____
Address of Prescribing Doctor

_____
Contact No

The medication has been prescribed for the following reason:

_____

_____

I hereby give permission to the Principal to obtain relevant information from the Prescribing Doctor.

I accept and agree that it is my responsibility to:

1. Provide the medication and equipment for its administration and to ensure its immediate replenishment after use.
2. Take note and diarise the expiry date of my child's medication to ensure that it remains current.
3. Inform the school in writing of any changes involving the administration of medication for my child.

_____ _____
Parent/Guardian Signature ***Date***

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FORM 2
TO BE COMPLETED BY PRESCRIBING DOCTOR
and returned to School Office

Medical Advice to School

Child's Name: _____

1. Medical condition(s) of the child requiring regular treatment:

_____

_____

Essential medication requiring administration during school hours:

MEDICATION DETAILS					
Condition Name	**Medication Name**	**Dosage**	**Time/s of Admin**	**Special Instructions**	**Self-Admin (YES / NO)**

2. Recommended restrictions on participation in school activities (eg. sport, use of tools or machinery):

_____

_____

3. Recommended procedure in **CRISIS situation**:

_____

_____

_____

5. Additional Comments:

_____

_____

_____ _____

Prescribing Doctor's Signature ***Date***