Kinross Primary School

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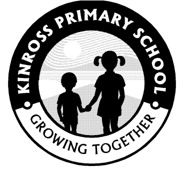

STUDENT MEDICATION REQUEST

NOTE:

Where possible student medication should be self-administered by the student or be administered by parents at home at times other than during school hours. If the Principal of the school is to approve of school staff administering or supervising the administration of medication to a student, then the following requirements must be met.

Drugs for administration should be delivered to the schools into the care of a staff member. The school will prepare a student medication record and store the drugs in a secure place. All drugs should be contained in properly labelled containers showing the name of the drug, the name of the student and the appropriate dose and frequency.

(Please print)

Name of parent/guardian/carer ____

Name of student ________________________________Date of Birth _____________

Current School ____

Name of prescribing doctor ____

Medical condition being treated ____

____

Name of drug ____________________ Dose ____________Time to be taken ______

(It is the responsibility of the parental/guardian/carer to provide the correct drug properly labelled. Improperly labelled drugs will not be administered).

Commencement date ____

Conclusion date ____

Replacement date of drug if appropriate ____________________________________

Comments (any additional information may be attached).

Note: 1 A new request / record agreement needs to be made:

- If the dose or medication type is altered;
- If the regime is re-started following the expiration of this order;
- At the beginning of each NEW calendar year;
- If the designated teacher alters.

Note: 2 This agreement form is only valid in conjunction with Appendix 2 of instructions from the prescribing doctor.

______________________________ ______________________________

Parent / guardian / care giver DATE Principal DATE
(Please specify which applies)

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MEDICATION INSTRUCTIONS FROM PRESCRIBING DOCTOR

These instructions are requested from the prescribing doctor to enable the school to maintain its 'duty of care' when administering prescribed drugs to students whose condition would otherwise preclude attendance at school.

Dr ____

Address ____

Telephone ____

I have prescribed the drug ____

for (name of student) ___________________________Date of Birth ____________

to treat the condition of (name of medical condition) _________________________

This drug needs to be administered (dose) _______________________________

(frequency / time) ____

Are special arrangements necessary to administer the drug or monitor the student after drug administration? Yes ☐ No ☐

If so, provide details below ____

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________________________________ ____________________

(signature of Prescribing Doctor) DATE

Kinross Primary School

STUDENT MEDICAL EMERCENCY REQUEST

Parents / guardians / carers are requested to supply the school with information on conditions such as asthma, diabetes and serious allergic reaction or any other condition that may give rise to a medical emergency situation. A separate form must be completed for each medical condition.
Advice on the action required by the school should also be provided.
Please cross out those sections below that are not applicable.

Name of Student: ______________________________ Date of Birth ____________

I ________________________ request that ____________________________School
(Parent / guardian / carer of student, please circle which),
take the following action should my child require emergency medical attention.

Medical condition: ____

Telephone / transport my child to:

Doctor ____

Address ____

____

Telephone No. ____

Hospital ____

Any special transport requirements: ______________________________________

Other action requested: ____

Period for which this request applies: ____________________________________

Administer medication as prescribed by Doctor ______________________________

and in accordance with instructions of the Appendix 1 and Appendix 2 for my child.

Comments: ____

____

____

Signature of parent / guardian / carer) ____________________Date _____________

(Signature of Principal) ________________________________ Date _____________

Kinross Primary School

EMERGENCY ACTION PLAN

Name of Student: ____

Date of Birth: ____

Problem: ____

Precautions: ____

ACTION PLAN

____

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____

____

Excursions Any special considerations:

Is attendance without extra assistance possible?

____

____

____

Signature of parent / guardian / carer ______________________ Date ___________

Signature of Principal __________________________________ Date ___________