

REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION TO THE STUDENT

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

Name of Prescribed Medication: _____

Prescribed for (name of medical condition): _____

Prescribed dosage: _____

What are you requesting the school to do?: _____

Special storage requirements if any (eg in refrigerator): _____

Special instructions for administering the prescribed medication (eg must be taken with food or with water): _____

Through information you have obtained 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 medication at home, do you request that he or she self administers this medication at school? ☐ **Yes** ☐ **No**

(Note: The Principal needs to approve a decision for a student to self administer)

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: _____

REQUEST FOR OTHER SUPPORT

Signed: _____ Date: _____

Parent/Guardian

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 and Training 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.