Student Medication Plan

Under the Information Privacy Act (2000) and Health Records Act (2001) schools have a legal obligation and duty to protect the individual with regard to their personal and health information. The information collected in this form is kept in confidence and only be used for the purpose of providing appropriate care of your child. Only school staff members who are
responsible for assisting or supervising the student taking medication at school will have access to this information.
This health information is needed so that staff can properly care for your child. Withholding any relevant health information can put your child's health at risk.

All medication must be brought to school in its original package and labelled with your child's name, dose to be taken and when it should be taken. Medication will be kept according to the medication guidelines and distributed as required. If it is necessary or appropriate for your child to carry their own medication (e.g. asthma

puffers) it must be with the knowledge and approval of both teacher in charge and yourself.

Parent/ Guardian Consent

I give permission for the school to administer this medication. If my child's health condition deteriorates I give permission for the school to seek any medical attention that is deemed necessary by a medical practitioner.

Name of Parent/Guardian: ……. …….

(First Name) (Family name)
Signature:……. Date: ……/……./…….
Address: …… (H)……
…… (W)……..
Name of family doctor: …….. ……..
Emergency contact numbers:
Name: ……. Ph …….
……. Ph …….
…… Ph …….

Name of Student:

…… ……
(First Name) (Family Name)

Student's medical Condition*

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- if your child has an ongoing medical condition(eg asthma, epilepsy, diabetes) then a relevant medical management plan needs to be completed.

Name of Medication/s	Dosage	Time to be taken	How it is to be taken? (Orally/ puffer/ injection/ via PEG)	Dates
				Start date: / / End date / / □ Ongoing medication
				Start date: / / End date / / □ Ongoing medication
				Start date: / / End date / / □ Ongoing medication
				Start date: / / End date / / □ Ongoing medication
				Start date: / / End date / / □ Ongoing medication

Storage
Does the medication require refrigeration? Yes / No
Staff member to complete.
Where will the medication be stored at school?.....
Medication received by:

Signature……. Date:……