APPENDIX 2

PARENT REQUEST for Administering Prescribed Medication (Schedule 4 & 8) to a Student.

PRESCRIPTION

(To be complete by parent / guardian)

I.....request that my son/daughter.....

of class .....be allowed to take medication at school under adult supervision according to instructions from:

Prescribing Doctor: .....

Address: .....

.....

Phone .....

I give permission to the principal to obtain relevant information from the Prescribing Doctor.
I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medication.

Signed: .....Date:.....

(Parent/Guardian)

Appendix 3

Medical Practitioner Advice to School

PRESCRIPTION

Section A

(To be completed by the parent/guardian)

The Principal of .....School seeks information which would assist the staff of St

Aloysius Catholic Primary School in administering medication to my child .....

I hereby give my permission for the necessary information to be supplied to the school.

I understand that the information so disclosed may be discussed by the principal of the school with other members of the staff in order to assess the ability of the school to meet my child's medical requirements.

Signed: ..... Date: .....

(Parent/Guardian)

Section B

Medical Practitioner stamp here

(To be completed by a medical practitioner)

Medical condition(s) of the child requiring treatment:

1: .....

2: .....

Medication to be administered during school hours:

For Condition (1,2 etc)	Name of Medication	Dosage amount	Time to be administered	Additional information

Signed: .....Date:.....

(Medical Practitioner)