WALK IN NEW LIFE

MATER MARIA CATHOLIC COLLEGE

COMMUNITY • FORMATION • SUCCESS

Please attach photograph of student here

REQUEST TO ADMINISTER MEDICATION AT SCHOOL

This form is to be completed by the parent/carer with the Prescribing Health Practitioner and returned to the College Administration Office or alternatively scan/email to studentservices@dbb.catholic.edu.au.

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

Student Name ……

Gender …… **Year Group** ……

Date of Birth ……

Name of Prescribed Medication: ……

Dosage (eg 5mg) ……

Route of administration (eg oral, by injection)……

Time of administering ……

Instructions for administering the prescribed 'over the counter' medication (eg must be taken with food or water)

……

Prescribed for (name of medical condition) ……

Medication Storage instruction ……

Are there any likely side effects from the medication? Yes ☐ No ☐

Describe the side effects ……

If your child administers his/her own medication at home, do you request that he/she self-administers this medication at school? Yes ☐ No ☐

Please describe the support your child needs to administer the medication in a non-emergency situation at school. You may like to include information about how you support your child at home to administer their medication.

……

5 FOREST ROAD WARRIEWOOD NSW 2102 AUSTRALIA ABN 63 423 792 086
TELEPHONE 02 9997 7044 FACSIMILE 02 9997 6042 EMAIL mmw@dbb.catholic.edu.au WEBSITE www.matermaria.nsw.edu.au

MATER MARIA CATHOLIC COLLEGE
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REQUEST TO ADMINISTER MEDICATION AT THE SCHOOL

I request that College staff administer the necessary medication to this student,

Student Name …… **DOB** ……

while at school. I confirm the above information provides Mater Maria Catholic College with the complete and necessary information to administer the medication. I also understand and agree that it is my responsibility (parent / guardian) to provide the College with the prescribed or 'over the counter' medication and inform the College Administration of any changes involving the administration of the medication and will do so in writing as specified in the 'Administration of Medication in Schools Policy' and 'Guidelines for Administering Medications in Schools' for Diocesan Systemic Schools.

Parent / Guardian (please print)

Name ……

Address ……

Home/Work/Mobile Telephone ……

Signature: _____ **Date:** ☐☐ / ☐☐ / ☐☐☐☐

Prescribing Health Practitioner (please print)

Name ……

Practice Address ……

Telephone …… **Email** ……

Qualifications: ……
Apply Practice Stamp Here

Signature: _____ **Date:** ☐☐ / ☐☐ / ☐☐☐☐

This authorisation applies for the period of ☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐

NOTE: For **College staff** to administer any medication including '*over the counter medication*', **authorisation is required from a Prescribing Health Practitioner.**

Privacy notice: The information requested on this form is essential for assisting the College to plan for the support of your child's health needs. It will be used by the College 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 College'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 via emailing studentservices@dbb.catholic.edu.au.

Office Only: *Completed form is to be scanned to the Student's File* ***<Surname><first initial><student number>Medication<year><date>***

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