Holy Spirit College
A Catholic Coeducational Secondary College

T: 02 4285 2877 F: 02 4285 2914
E: info@hscdow.catholic.edu.au
W: hscdow.catholic.edu.au
2 Cawley Street Bellambi NSW 2518
PO Box 63 Corrimal NSW 2518

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

1. Student Details

First name: _____Surname: _____
Date of Birth: _____School:_____ Class: _____

2. Health / Medical Condition

Please complete a separate request for each health/medical condition requiring medication.

Medical Condition: _____
Details:_____
_____
_____

Could your child experience an emergency reaction in relation to this condition? Yes ☐ No ☐
If yes, please provide details of reaction:

_____
_____
_____

Has medication been *prescribed* by a medical practitioner for this condition?
Yes ☐ **(please complete Section 3)** No ☐
Is Over-The-Counter medication required for this condition? Yes ☐ **(please complete Section 3)** No ☐

OVER-THE-COUNTER MEDICATION

NOTE: Over-The-Counter medication will not be administered by school staff unless the below has been stamped and signed by a Medical Practitioner.

Apply practice stamp here:

Medical Practitioner Signature: _____
Date: _____

3. Medication Instructions

Name of medication: _____ Dosage: _____
Time required to be administered: _____

Commencement date: _____Conclusion date:_____
Expiry date of the medication: _____

Special storage requirements if any (e.g. in refrigerator):

_____
Special instructions for administering the medication e.g. must be taken with food:

_____
Are you aware of any likely side effects from the medication? Yes o No o
If yes, please provide details of side effects:

_____

_____

4. Medical Practitioners Contact Details

In an emergency requiring medical attention, I authorise the school to contact:
Medical Practitioner's name/medical centre: _____
Address: _____Phone number: _____

5. Carry / Self-Administer Medication Request

For some medications and some students, it can be appropriate for the student to self-administer their medication without any adult supervision, and carry their own medication to and at school.

Would you like the school to consider a request for your child to carry and self-administer their own medication?

Yes ☐ No ☐
If yes, please provide details of what medication your child will carry, and where your child will store their medication (e.g. in a medical pouch)?

_____

_____

***Principal or their delegate will assess any associated risks at the school level before approving a student to self-administer and carry their own medication.**

****Schedule 8 drugs (e.g. Ritalin) must be kept in the administration office due to the safety risk posed to other students.**

6. Parent / Carer Contact Details

Name:_____
Relationship to child: _____
Address: _____
Home phone: _____ Work phone: _____
Mobile phone: _____ Email: _____
Parent / Carer Consent Signature: _____Date: _____