



Request for support at school of a student's health condition 2019

Request for administering prescribed medication to student

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

Student details

First name:..... Last name:.....
Date of Birth:..... Grade:.....

Medical Condition and Medication

Medical Condition the medication is prescribed for:

- Anaphylaxis Asthma (severe) Asthma
- Allergy.....(specify) Other (please list below)

Has this condition been diagnosed by a doctor? Yes/ No

Doctor's Name: Phone:.....

Name of prescribed medication:.....

Prescribed dosage:.....

What are you requesting the school to do?

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Expiry date of the medication:

Special storage requirements if any e.g. in refrigerator

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Special instructions for administering the prescribed medication/s e.g. must be taken with food or with a glass of water:

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Through information you have obtained from your doctor or got yourself, are you aware of any likely side effects from the prescribed medication?

Yes/ No If Yes, Please provide more information:

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If your child administers his or her own 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 yes, please describe what 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.

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Secure delivery of prescribed medication is important for the safety of your child as well as for the safety of other students in the school.

Please name the person who will carry the medication to school:

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Note: if you are unable to deliver the medication to school, it is advisable that you nominate a responsible person, who is not a school staff member, to transport the medication to the school.

For some medications and some students it can be appropriate for them to carry their own medication to and at school. For example, asthma reliever medication and pancreatic enzymes for cystic fibrosis. If your child is to carry their own medication we want to be able to support this and request some information so that we are well informed.

Note: The school may still need you to provide the school with an additional supply of the medication for storage in central location/s within the school and for use if your child needs the schools help.

Would you like the principal to consider a request for your child to carry their medication?

Yes No

Note: The Principal needs to approve a decision for a student to carry their own medication at school.

If yes, please describe where and how your child will carry this medication, for example, my child will carry it on their person in a medical pouch or bum bag.

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Request for other support

Please provide details of any other health care support needs of your child while they are at school and involved in school activities.

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Parent/Carer Name:..... Date:.....

Signature:.....

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 Communities 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.