

BRIGHTON CATHOLIC PRIMARY SCHOOL

Connolly Drive, Butler WA 6036

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To be confidentially stored until the	he student is 25 years old.
Year document is to be destroyed	(year)

STUDENT MEDICATION REQUEST AND AGREEMENT

NOTE

Where possible, student medication should be self-administered by the student or be administered by parents or care-givers at home, at times other than during school hours.

If the Principal of the school is to approve of school staff administering, or supervising the administration of medication to a student, then the following requirements must be met.

The doctor prescribing the drug must be aware that the school will supervise or carry out administration of medication on the instructions provided. It is therefore necessary that the doctor provide additional instructions to staff regarding special requirements as per the 'Medical Instructions from Prescribing Doctor' form. These instructions are a mandatory requirement and are necessary when school staff are to administer the drug, supervise the administration of the drug, or monitor the student after drug administration.

Drugs for administration should be delivered to the school into the care of the class teacher. The school will prepare a student medication record and store the drugs in a secure place. All drugs should be contained in properly labelled containers showing the name of the student and the appropriate dose and frequency.

(Please Print)				
Name of parent/guardian/carer				
Telephone Nos. (H)	(W)	(M)		
Name of Student				
Year level of Student				
Date of Birth				
Name of prescribing doctor				
Medical condition being treated				
Name of drug				
	Time to be taken			
	Time Last A	Time Last Administered		

(It is the responsibility of the parent/guardian/career to provide the correct drug properly labelled. Improperly labelled drugs WILL NOT be administered.)

Possible	e side effects					
Comme	ncement Date		Conclusion date			
Replace	ement date of drug if	appropriate				
Comme	ents (any additional i	nformation may be attached	ed)			
Emerge	ncy Contacts if unal	ole to contact parents/guard	lians/carers (2 required)			
1.	Name					
	Relationship to child	1				
,	Telephone					
2.	Name					
	Relationship to child					
	-					
I agree	to waive any claims	information may be given of liability that may arise and to the child according to	ngainst any school persor			
Signature of parent/guardian/carer		n/carer	Date			
Signatu	re of Principal		Date			
Tim	e Date	Medication	Administered by (Signature)	Witnessed by (Signature)		