

MUELLER COLLEGE
STUDENT MEDICATION REQUEST FORM

This form must be completed for medication to be administered to your child during school hours. It has been designed to ensure the safety of your child and to protect school staff who do not have medical training.

Section 1 is to be completed by your child's medical practitioner. **Section 2** is to be completed by you.
Please return the completed form to the school.

Where possible, medication should be administered to your child at home at times other than during school hours. For staff to undertake to assist in administering medication to your child, the following requirements must be met:

1. Your child's medical practitioner must provide the information required in Section 1 below;
2. All medication supplied to the school for your child must be in a container labelled by a pharmacist, showing the name of the drug, the "use by" date, the name of the student's medical practitioner, the name of the student, the dosage and the frequency of administration.

SECTION 1
MEDICATION INSTRUCTIONS FROM THE MEDICAL PRACTITIONER

Management Plan These instructions are requested from the student's medical practitioner to enable the school to maintain its *duty of care* when administering medication to students whose condition would otherwise preclude attendance at school.

Medical Practitioner's Name: _____

Address: _____

Phone: _____

Name of Student: _____ Condition: _____

Name of Medication: _____ Self-administer: (yes / no) _____

Dose: _____ Time to be taken: _____

Commencement date: _____ Conclusion date: _____

Special arrangements (eg. Monitoring the student after administration; restrictions on participation in school activities such as sports or use of machinery; side effects; emergency actions.)

Signed: _____ Date: _____
(Student's Medical Practitioner)

SECTION 2
NOTIFICATION AND REQUEST BY PARENT/PERSON WITH LEGAL RESPONSIBILITY FOR STUDENT FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

I request administration of medication as instructed above.

Full name of Student: _____ D.O.B. _____ Grade: _____

Note 1: A new Student Medication Request Form must be completed:

- If the dose or type of medication is altered;
- If the regime is re-started following the conclusion date of the instructions from the medical practitioner above;
- At the beginning of each new calendar year.

Note 2: This Form is only valid when instructions from the student's medical practitioner have been provided above.

Signed: _____ Date: _____
(Parent / Guardian) Contact Phone No: _____